Amend Item 23a,.Pt 1, per Dr.,G808,06/07/02dbb

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

AMEND ITEM #23a &23 PII PER PHY G808 6/05/02 JH

2002 18001
Reg. No.

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Clayton Swears

2. Date of Death: Month May Dey 27 Year 2002

3. Time of Death: 2108

4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

5. Social Security Number: 094-01-8205

6. Sex: XX M 2☐ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): Aug. 13, 1915

9. Birthplace (State or Foreign Country): New York

Usuel Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Odenton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 509 Gladhill Road

10f. Zip Code: 21113

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1948-72

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Colonel

16b. Kind of Business/Industry: U.S. Army

17. Father's Name (First, Middle, Last): Claude J. Swears

18. Mother's Name (First, Middle, Maiden Surname): May Anita Cole

19a. Informant's Name/Relationship (Type, Print): Nancy A. Swears (Wife)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 509 Gladhill Road, Odenton, MD 21113

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.

Date: 07/08 2002

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Robert J. Hardesty

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

SUBARACHNOID HEMORRHAGE

a. ~~Pulseless Electrical Activity Arrest~~ — Two Months ~~Fifteen minutes~~

Due to (or as a consequence of):

b. Atrial Fibrillation — One Month

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

Due to (or as e consequence of):

c. Ventricular Tachycardia — One Month

Due to (or as a consequence of):

d.

23a

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~Subarachnoid Hemorrhage~~

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kerri, Resident

29c. License number: RES-000

29d. Date signed (Month, Dey, Yeer): May 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kerri Armon Johns Hopkins Hospital 600 North Wolfe Street, Baltimore, Maryland 21205

State Registrar

31. Date filed (Month, Day, Year): JUN 05 2002

32. Registrer's Signature: Bernice B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pegas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, paga 2 should be datached for use as tha burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2002 18002

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN · A. TORRES

2. Date of Death Month / Day / Year: JUNE 4, 2002

3. Time of Death: 7 40 AM

4a. Facility Name *(If not institution, give street end number)*: Baltimore VA Medical Center Greene ST.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 572.78-8782

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 51 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 16, 1950

9. Birthplace *(State or Foreign Country)*: CA.

Usual Residence of Decedent

10a. State: PA.

10b. County: ADAMS

10c. City, Town or Location: GETTYSBURG

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 4820 OLD HARRISBURG RD.

10f. Zip Code: 17325

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No — If Yes, Give Year or Dates: U.S ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: SHIPPING CO.

17. Father's Name *(First, Middle, Last)*: OTHON TORRES

18. Mother's Name *(First, Middle, Maiden Surname)*: GWEN McDONALD

19a. Informant's Name/Relationship *(Type, Print)*: VICTORIA MARTIN - TORRES

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 4820 OLD HARRISBURG RD. GETTYSBURG PA - 17325

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EVERGREEN Cemetery — Date: 6/6/02

20c. Location - City or Town, State: GETTYSBURG, PA.

21. Signature of Funeral Service Licensee: Paul M Stella

22. Name and Address of Facility: HARTLEY MILLER — STELLA FUNERAL HOME CHTD. 7527 HARFORD RD. Balto MD 21234

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

e. Renal Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

b. Diabetes

Due to (or es e consequence of):

c. Infection

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: Erinn E. Maury

29c. License number: P15791

29d. Date signed *(Month, Day, Yeer)*: JUNE 4, 2002.

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): ERINN E. MAURY, MD 10 N. GREENE ST.

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 04 2002

32. Registrer's Signature: Jennifer D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificete has been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

02-2829-510
LARRY WALLACE
RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18003

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
LARRY	ISAAC	WALLACE	MAY	29,	2002	5:35P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4839 WILERN AVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-42-8425	1 [X] M 2 [ ] F	59 Yrs.					JUNE 17, 1942	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4839 WILERN AVENUE	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10TH GRADE		SHORT ORDER COOK	MILLER'S DELI

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN	LORETTA WALLACE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
EMMA ROYAL-DAVIS (FRIEND)	4839 WILERN AVE., BALTIMORE, MD. 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	METRO CREMATORY	06-05-02	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: J. Brown

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

28a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Alcoholism

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [✓] Yes 2 [ ] No	1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Pestaner, M.D.	O.C.M.E.	MAY 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 05 2002	Geneva B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Delores Williams	May 31 2002	2:15A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis, Maryland	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-16-3888	1☐M 2☒F	77 Yrs.			4/07/1925	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Lansdowne	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
204 Hillendale Avenue	21227	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Machine Operator	Manufacture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Irvin Bennett	Mary Llufrio

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kenneth R. Williams/ Son	9500 Powderhorn Lane Baltimore, Maryland 21234

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen Haven Cemetery	6/04/2002	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Titus Abraham	D0056658	May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Titus Abraham, M.D. Anne Arundel Medical Center 2001 Medical Parkway Annapolis, Md 21401

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 05 2002	Geraldine B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ELLA L. WRIGHT	JUNE 3 , 2002	5:12P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOSEPH RICHIE HOSPICE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-26-5545	1☐M 2☐F X	71 Yrs.			NOV.11,1930	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☐Yes 2☐No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
216 N.PATTERSON PK. apt 2	21231	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☐No X Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9TH		TECHNICIAN	HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CARRINGTON WRIGHT	EDITH PARKER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KAREN GARRIS (DAUGHTER)	216PATTERSON PK. APT.2 BALTO,MD. 21231

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT. ZION CEMETERY	JUNE 12,2002	BALTO,MD.

21. Signature of Funeral Service Licensee: Bernadene V. Scruggs

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO,MD. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Squamous cell cancer of lung	>1yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☑Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
E Tso MD	D24170	June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E. Tso MD Richey Hospice 820 N. Eutaw St. Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 05 2002	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5:12pm 6/3/02 Silla Wright

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
ABRAHAM	WEISS	June 2 2002	7:32 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-26-7714	XX 1 M 2 F	92 Yrs.			JULY 11, 1909	N.D.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2331 OLD COURT ROAD #500	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married XX Married 3 Widowed 4 Divorced	1 Yes XX No If Yes, Give Year or Dates:	1 Yes XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		INVESTOR	REAL ESTATE

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
MORRIS	WEISS	GUSSIE	TEITELBAUM

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
VIRGINIA WEISS / WIFE	2331 OLD COURT ROAD #500 - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ARLINGTON CHIZUK AMUNO	6/4/2002	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward C. Rund	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction — 30 wks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery Atherosclerotic Disease — YEARS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 ☑ No

25. Was case referred to medical examiner? 1 Yes 2 ☑ No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☑ ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 ☑ Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Tariq Khan	D0021730	June 2 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tariq Khan 2401 W. Belvedere Ave. Baltimore Md. 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 05 2002	Regina D Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18007

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Mary Helen Alvey	May 18 2002	7:15P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Prince Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-72-3834	1☐M 2☒F	90 Yrs.			April 24, 1912	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Mechanicsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
37855 Newmarket Turner Road	20659	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Henry Pilkerton	Odie Ester Gatton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Bernard Alvey Son	27430 Three Notch Rd, Mechanicsville, MD 20659

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sacred Heart Cem.	May 24 2002	Bushwood, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael K Gardiner	Mattingley Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown Maryland 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Peripheral Vascular Disease with Ulceration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atrial Fibrillation.

Due to (or as a consequence of):

c. Embolic Phenomin to Bilateral Lower Extremity.

Due to (or as a consequence of):

d. Diabetes Mellitus.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☒No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
W. Michael Mahaffey	D47443	5-19-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. Michael Mahaffey, M.D., 24035 Three Notch Road, Hollywood, MD 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Edna	Marian	Burdette	May 19, 2002	12:50 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Bayside Care Center	Lexington Park	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-28-1835	1☐ M 2☒ F	70 Yrs.			Aug. 17, 1931	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Lexington Park	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
21412 Great Mills Road	20653	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th		Book Binder	Printing Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Alexander Colley	Edna May Lockner

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Priscilla B. Russell	14739 McArthur Drive, Scotland, Maryland 20687

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Brinsfield-Echols	5/21/2002	Charlotte Hall, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward N. Brinsfield, JR. M00052	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular Accident	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Type II Diabetes

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
SC Bailey M.D.	D 54346	5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
C. Sajja, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18009

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary Virginia Blackburn	May 23 2002	0750 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harford Memorial Hospital	Havre de Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-20-9096	1☐ M 2☒ F	89 Yrs.			Sept. 6, 1912	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Port Deposit	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
75 North Main Street	21904	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Twelve Years		Accountant	C. Curtis Morgan Aberdeen, Maryland

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Clifton M. Blackburn, Sr.	Annie V. Lynch

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dana M. Stewart (niece)	75 North Main St., Port Deposit, MD 21904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hopewell Cemetery	05/28/02	Port Deposit, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Thomas M. Patterson, Sr.	Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia, Alzheimer's type

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Manuel M. Lazatin MD	D19583	May 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MANUEL M. LAZATIN MD 8 Law Street / Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5/23/02 0750

Blackburn, Mary Virginia

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JOHN WILLIAM BOWLING	MAY · 17 · 2002	4 15 AM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Levindale Hospital	Baltimore City	None

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
None	1 X M 2 ☐ F	67 Yrs.			July 11 1934	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		Baltimore City	1 ☐ Yes 2 ☐ No X

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
2434 West Belevedere Avenue	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Disabled	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John C. Bowling	Maybelle Yingling Bowling

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jacob M. Yingling (Cousin)	24 Kalten Road Westminister, MD 21158

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Trinity Memorial Gardens	5-20-02	Waldorf, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John A Eberwein M00173	Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Congestive Heart Failure	7 6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary artery disease	7 6 months
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Organic Brain Syndrome —

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Meyami MD	D44817	May · 17 · 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Syed T. Rejaie 2434 W Belvedere Ave, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law raquiras that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attending physician end completely filled in by the funeral director, pega 2 should be datached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Grace Lillian Burns	May 1, 2002	11:25 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
23140 Cobblestone Lane Apt.#204	California	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
061-14-7252	1☐ M 2☒ F	88 Yrs.			December 31, 1913	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	California	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23140 Cobblestone Lane Apt.# 204	20619	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Registered Nurse	Doctors Office

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Metzger	Lillian Schaeffer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Faith P. Roache / Daughter	28140 Three Notch Road Mechanicsville, MD 20659

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	May 4, 2002	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael L Gardiner	Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Invasive endometrial cancer	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D42597	5-3-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey C. Brown MD, Shanti Medical Center, Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 3 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(12)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion Carter Campbell
2. Date of Death (Month, Day, Year): MAY 24 2002
3. Time of Death: 4:40 a M
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 218-22-4708
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 3, 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Ridge
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 48588 Wynne Road
10f. Zip Code: 20680
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Board of Education

17. Father's Name (First, Middle, Last): William Smallwood
18. Mother's Name (First, Middle, Maiden Surname): Edith Carter

19a. Informant's Name/Relationship (Type, Print): Cynthia Campbell-Young-Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7702 Foxhall Road, Clinton, Maryland 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Zion Methodist
Date: 6/1/2002
20c. Location - City or Town, State: St. Inigoes, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End stage Renal Disease — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: SC Gaby M.D.
29c. License number: D54346
29d. Date signed (Month, Day, Year): 5/26/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHANDRA SAJJA,MD PHILIP J. BEAN HOLLYWOOD, MD 20636

State Registrar

31. Date filed (Month, Day, Year): MAY 30 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: MARION CARTER CAMPBELL

on 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18013

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Richard	Case	Crickmer	May 23, 2002	5:30 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Charlotte Hall Veterans Home	Charlotte Hall	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
469-01-1266	1 [X] M 2 [ ] F	84 Yrs.			Aug. 26, 1917	Wyoming

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
44992 Steer Horn Neck Road	20636	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Sales	Industrial Cleaner

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Reginald Crickmer	Nolie Sedalia Case

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20636
Thomas Crickmer (Son)	44992 Steer Horn Neck Road, Hollywood, Maryland

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Brinsfield-Echols	5/23/2002	Charlotte Hall, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Peter Pitchard	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonra	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Failure to Thrive	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease
Adenocarcinoma of the Liver

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0052097	5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Janelle Bell, MD 590 Main St., Prince Frederick, MD 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

CRICKMER, RICHARD C 469-01-1266 MAY 23, 2002 5:30AM

Milissa Ann Coale
02-2585-015
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Melissa Ann Coale	May	19	2002	1:52 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Route 1 near Conowingo Dam	Conowingo	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-78-8139	1☐M 2☒F	30 Yrs.					Oct. 8, 1971	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Conowingo	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
281 McGlothlin Road	21918	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Operator	Solar Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harold E. Montgomery, Jr.	Susan E. White

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Harold E. Montgomery, Jr.	75 Longview Drive, Colora, MD 21917

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Brookview Cemetery	5-24-2002	Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie

22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen Street, Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☒Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death 1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year): 5/19/02

28b. Time of Injury: 01:41 P.M.

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: SUBJECT WAS PEDESTRIAN STRUCK BY VEHICLE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROAD

28f. Location (Street and Number or Rural Route Number, City or Town, State): RT 1 - FRONT OF STARGILLS, CECIL COUNTY

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	May 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA KUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	Bonnie G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

rgw

12

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sadie Marie Chase

2. Date of Death (Month, Day, Year): May 3, 2002

3. Time of Death: 2:30 A M

4a. Facility Name (If not institution, give street and number): 46173 Sydney Drive

4b. City, Town, or Location of Death: Lexington Park

4c. County of Death: St. Mary;s

Funeral Director

5. Social Security Number: 218-24-0648

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 25,1928

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Lexington Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 46173 Sydney Drive

10f. Zip Code: 20653

10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Benedict O. Hopewell

18. Mother's Name (First, Middle, Maiden Surname): Lillia Smith

19a. Informant's Name/Relationship (Type, Print): Sister Marilyn Hopewell Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16710 Bennett Drive, Ridge, Maryland 20680

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Peter Claver

Date: 5/8/2002

20c. Location - City or Town, State: St. Inigoes, Maryland

21. Signature of Funeral Service Licensee: Mary Kizzo M01114

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinomatosis — 3 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pancreatic Cancer — 6 mo

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Jarboe M.D.

29c. License number: D 06419

29d. Date signed (Month, Day, Year): 5-3-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James P. Jarboe, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year): MAY 07 2002

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18016

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
John	Darnell	Curtis	April 29, 2002	3:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
22497 MacArthur Boulevard	California	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-74-7001	1☒M 2☐F	42 Yrs.			Sept. 16, 1959	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	California	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
22497 MacArthur Boulevard	20619	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		Cook	Food Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Peter Xavier Curtis	Margaret Gertrude Mills

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
George F. Curtis (Brother)	27017 Yowaiski Mill Road, Mechanicsville, MD 20659

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mary Immaculate Heart of	5/3/2002	Lexington Park, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Mary Rizzo MO1114	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinomatosis — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cancer of Tonsil — yr.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Patrick Jarboe, MD	D06419	4-30-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Patrick Jarboe, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 3 2002	

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ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18017

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Lou Clark
2. Date of Death (Month, Day, Year): May 20, 2002
3. Time of Death: 9:05 a M
4a. Facility Name (If not institution, give street and number): 912 Kitzmiller Road
4b. City, Town, or Location of Death: Kitzmiller
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 212 24 2220
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 10 1926
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: Md
10b. County: Garrett
10c. City, Town or Location: Kitzmiller
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 912 Kitzmiller Rd.
10f. Zip Code: 21538
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Saleperson
16b. Kind of Business/Industry: GC Murphy

17. Father's Name (First, Middle, Last): Harper McRobie
18. Mother's Name (First, Middle, Maiden Surname): Hazel Schmidt

19a. Informant's Name/Relationship (Type, Print): Donna Broadwater
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 380 Meadow Mtn. Trails Swanton, Md 21561

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): IOOF Cemetery
Date: 5/20/02
20c. Location - City or Town, State: Elk Garden, WV

21. Signature of Funeral Service Licensee: David A. Burdock
22. Name and Address of Facility: David A. Burdock FH 710 Church St. Kitzmiller, Md 21538

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Intractable Systolic Heart Failure — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Coronary Artery Disease — 10 years
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Type II

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margaret A. Kaiser
29c. License number: D26650
29d. Date signed (Month, Day, Year): 5/20/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margaret A. Kaiser MD 13079 Garrett Highway Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18018

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Elizabeth Carr
2. Date of Death: Month 5 Day 15 Year 02
3. Time of Death: 255 A M
4a. Facility Name (If not institution, give street and number): 2604 Cove Rd
4b. City, Town, or Location of Death: Accident
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 233-70-6606
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 8, 1913
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Accident
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2604 Cove Road
10f. Zip Code: 21520
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Franklin Reeves McCray
18. Mother's Name (First, Middle, Maiden Surname): Mary Grace Conaway

19a. Informant's Name/Relationship (Type, Print): Sally A. Schwing/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2604 Cove Rd., Accident, MD 21520

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WVU Human Gifts Regis.
Date: May 15, 2002
20c. Location - City or Town, State: Morgantown, WV

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Crantsville, MD 21536

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Arteriosclerotic coronary vascular Disease years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ P Daniel Miller DO
29c. License number: H26154
29d. Date signed (Month, Day, Year): 5/15/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. Daniel Miller DO. 186 Thornberry Rd Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year): MAY 16 2002
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

02-2617-025
MARIE A. DRAUDE
RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 060702:ITEMS#23a,27,28a-f per ME G808 ss

Certificate of Death

Reg. No. 2002 18019

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Marie A. Draude	MAY 20, 2002	2:15P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GLEN COVE MARINA	DARLINGTON	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
170-28-7896	1☐M 2☒F	65 Yrs.			June 12, 1936	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Lancaster	Lancaster	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
59 S. Pearl Street	17603	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		waitress	food service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Voci	Angeline Paparo

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Francis J. Draude/husband	59 S. Pearl St., Lancaster, PA 17603

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Joseph New Catholic Cemetery	May 24, 2002	Lancaster, PA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility R.T. Foard Funeral Home, PA
111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPHYXIA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. DROWNING
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	5/20/02	11:37 M	1☐Yes 2☑No	Subject drove vehicle into water ~~Decedent in car submerged~~

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in car in water ~~Glen Cove Marina - underwater~~

28f. Location (Street and Number or Rural Route Number, City or Town, State) ~~Glen Cove Marina~~ Darlington, Harford County, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	MAY 21,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Agatha Theresa Dean

2. Date of Death (Month, Day, Year): May 1, 2002

3. Time of Death: 8:45 P M

4a. Facility Name (If not institution, give street and number): Bayside Care Center

4b. City, Town, or Location of Death: Lexington Park

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 468-18-6987

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 1, 1919

9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Compton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 21685 Joe Hazel Road

10f. Zip Code: 20627

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: United States Government

17. Father's Name (First, Middle, Last): Frank Kern

18. Mother's Name (First, Middle, Maiden Surname): Johanna Zabukavic

19a. Informant's Name/Relationship (Type, Print): Raymond A. Dean/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20755 Dearwood Parkway Leonardtown, Maryland 20650

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Francis Xavier Cemetery

Date: May 4, 2002

20c. Location - City or Town, State: Compton, Maryland

21. Signature of Funeral Service Licensee: [signature] 050106

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Approximate Interval Between Onset and Death: 1-2 d

Due to (or as a consequence of):

b. Intra Cerebral Hemorrage — 2-3 mth

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D19917

29d. Date signed (Month, Day, Year): 5/3/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James C. Boyd MD P.O. Box 730 Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year): MAY 3 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18021

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RUBY MAE DeWITT	MAY 18, 2002	4:56 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3620 WHITE CHURCH-STEYER ROAD	OAKLAND	GARRETT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-32-4672	1☐ M 2☒ F	68 Yrs.			MARCH 11, 1934	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	GARRETT	OAKLAND	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3620 WHITE CHURCH - STEYER ROAD	21550	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM LOUIS OTTO	LENA ELLEN GROVE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RANDY DeWITT - SON	3620 WHITE CHURCH STEYER RD. OAKLAND, MD 21550

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	DEER PARK CEMETERY	5/21/02	DEER PARK, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert H Durst M00167	DURST FUNERAL HOME - P.O. BOX 243 OAKLAND, MARYLAND 21550

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DIABETES MELLITUS TYPE II

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
P Daniel Miller DO	H26154	MAY 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. DANIEL MILLER, D.O. 69 WOLF ACRES DRIVE OAKLAND, MD 21550

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18022

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine M. Ebersole
2. Dete of Deeth: Month May Dey 16 Year 2002
3. Time of Death: 2215pm
4a Fecility Neme (If not institution, give street end number): Calvert Nursing Home
4b. City, Town, or Location of Deeth: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-20-2283
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): Jan.21,1916
9. Birthplace (State or Foreign Country): Wilmington, DE

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 85 Woods Way
10f. Zip Code: 21921
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): cook
16b. Kind of Business/Industry: Methodist Country House
17. Fether's Name (First, Middle, Last): Harry Simmons
18. Mother's Name (First, Middle, Maiden Surname): Clara L. Hollett
19a. Informant's Name/Relationship (Type, Print): Howard Ebersole (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 85 Woods Way Elkton, MD 21921
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gracelawn Memorial Park
Date: May 28,2002
20c. Location - City or Town, State: New Castle,DE
21. Signature of Funeral Service Licensee: Nicholas D. Scarfulla
22. Name and Address of Facility: McCrery Funeral Homes, Inc. 3924 Concord Pike Wilm., DE 19803

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — Idays
Due to (or as a consequence of):
b. Arteriosclerotic Heart disease — many yrs
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Chronic Arterial Fibrillation — few years
Due to (or as e consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: Jayantilal K Patel MD
29c. License number: D22307
29d. Date signed (Month, Day, Yeer): May 17, 2002
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JAYANTILAL K PATEL MD 123 SINGERLY AVE, ELKTON, MD 21921

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: Barbara D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Diane Dess Frericks
2. Date of Death Month Day Year: May 25, 2002
3. Time of Death: 12:15P M
4a. Facility Name (If not institution, give street and number): 21704 Ranger Rd.
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-68-3378
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 31, 1953
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21704 Ranger Rd.
10f. Zip Code: 20653
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Bus Driver
16b. Kind of Business/Industry: Bus Contractor

17. Father's Name (First, Middle, Last): Daniel Holland
18. Mother's Name (First, Middle, Maiden Surname): June Hilda Trusch

19a. Informant's Name/Relationship (Type, Print): Darleen Lynn Allen - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 663 21704 Ranger Rd. Lexington Park, MD 20653

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens
Date: 05/29/2002
20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael K Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. General Debility

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
b. metastatic cancer of cervix — 2 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Anemia
Left leg paralysis and peripheral vascular disease
Chronic back and Left leg pain

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: D0051738
29d. Date signed (Month, Day, Year): 5/28/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KAE T. AUNG 24435 MERVELL DEAN RD. HOLLYWOOD, MD 20636

State Registrar

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pauline Alfreda Frazee
2. Date of Death (Month, Day, Year): May 9, 2002
3. Time of Death: 6:35 p M
4a. Facility Name (If not institution, give street and number): Goodwill Mennonite Home
4b. City, Town, or Location of Death: Grantsville
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 214-42-0595
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 8, 1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Friendsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1238 Noah Frazee Road
10f. Zip Code: 21531
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Milton F. Friend
18. Mother's Name (First, Middle, Maiden Surname): Grace D. Sisler

19a. Informant's Name/Relationship (Type, Print): Ralph W. Frazee/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6458 National Pike, Addison, PA 15411

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Blooming Rose Cem.
Date: May 12, 2002
20c. Location - City or Town, State: Friendsville, MD

21. Signature of Funeral Service Licensee: ▶ D Lyn Newman
22. Name and Address of Facility: Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Systolic Heart Failure — Approximate Interval Between Onset and Death: 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Atrial Fibrillation — 1 year
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, Osteoporosis, Hypothyroidism

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Margaret A Kaiser MD
29c. License number: D26650
29d. Date signed (Month, Day, Year): 5/9/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margaret A. Kaiser MD 13079 Garrett Highway Oakland MD 21550

State Registrar

31. Date filed (Month, Day, Year): MAY 14 2002
32. Registrar's Signature: ▶ Brenda D Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ruth Evelyn Gatton	May 10, 2002	10:01 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-28-2463	1☐ M 2☒ F	84 Yrs.			March 3, 1918	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24475 Hollywood Road	20636	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Food Service Worker	Board of Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John William Gatton	Oster Mae Bond

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John O. Gatton, Sr. - Son	24429 Mervell Dean Rd. Hollywood, MD 20636

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Hollywood Church of the Nazarene	May 15, 2002	Hollywood, Maryland

21. Signature of Funeral Service Licensee: Michael K. Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Failure	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Congestive Heart Failure	wks
	c. Due to (or as a consequence of): Arteriosclerosis	yrs
	d. Due to (or as a consequence of): Coronary Artery Disease	yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
James P. Jarboe MD	D 06419	5-13-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES PATRICK JARBOE, MD 24035 THREE NOTCH RD HOLLYWOOD, MD 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 13 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(12)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18026

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Rolla Alton Gault	MAY 22, 2002	11:45P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VA MARYLAND HEALTH CARE SYSTEM	PERRY POINT	CECIL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
234-03-4232	1☒M 2☐F	84 Yrs.			April 2,1918	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Port Deposit	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23 Honeysuckle Drive	21904	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1943-44	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	one year	Mechanic	Domino Sugar Philadelphia, Pennsylvania

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Gault	Jenny Ricket

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William H. Gault (son)	23 Honeysuckle Drive, Port Deposit, Maryland 21904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	R.A. Ferris & Co.,Inc.	05/28/02	West Chester, Pennsylvania

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Thomas M. Patterson Sr.	Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

NAME KNOWN TO PHYSICIAN: ROLLA A. GAULT
Baltimore, Maryland 21215-0036

from

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PNEUMONIA — UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D52739	MAY 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	Barbara G Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

9+1 VK

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18027

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel Virginia Green

2. Date of Death: Month May, Dey 21, Year 2002

3. Time of Death: 12:45 PM

4e Facility Neme (If not institution, give street end number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Deeth: Talbot

Funeral Director

5. Social Security Number: 160-26-8245

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. lest birthday): 95 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Yeer): Dec. 18, 1906

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 201 Federal Street - Apt. 33

10f. Zip Code: 21601

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Eduction (Specify only highest grede completed): Elementery/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Dietary Worker

16b. Kind of Business/Industry: City College

17. Father's Neme (First, Middle, Last): Carroll Hemsley

18. Mother's Name (First, Middle, Maiden Surname): Lena Williams

19a. Informant's Name/Relationship (Type, Print): Russell Perkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9380 Unionville Road Easton, Maryland 21601

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Richard's Mem. Park

Date: 5/25/02

20c. Location - City or Town, State: Easton, Maryland

21. Signature of Funeral Service Licensee: Janelle C. Henry

22. Name and Address of Facility: Henry Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

To Be Completed by Funeral Director

Ethel Green

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): e. End-stage renal failure — years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Atherosclerosis, generalized — years

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Congestive heart failure

Glaucoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquiras thet the death cartificate be axecuted within 24 hours after death.

To the Funeral Director: After this cartificata has been signed by the attending physician and completaly filled in by tha funaral director, paga 2 should be detached for usa as tha burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: MD

29c. License number: D25933

29d. Date signed (Month, Day, Year): 5.22.02

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print): MICHAEL CROWLEY MD 508 IDLEWILD AVENUE EASTON MD 21601

State Registrar

31. Date filed (Month, Dey, Year): MAY 23 2002

32. Registrar's Signature: B. Smith

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18028

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LaDonna Marie Hinz
2. Date of Death: Month May, Day 29, Year 2002
3. Time of Death: 8:40 A M
4a. Facility Name (If not institution, give street and number): 39534 Potomac Avenue
4b. City, Town, or Location of Death: Compton
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 193-22-9606
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months; If Under 24 Hrs.: Days, Hours, Min.
8. Date of Birth (Month, Day, Yeer): October 13 1931
9. Birthplace (State or Foreign Country): Courtney, PA

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Compton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 39534 Potomac Avenue
10f. Zip Code: 20627
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Harry Elmer Watson
18. Mother's Name (First, Middle, Maiden Surname): Olga Rita Austin

19a. Informant's Name/Relationship (Type, Print): Daniel Ray Hinz Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 39534 Potomac Ave, PO Box 272, Compton, MD 20627

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MonongAhela Cemetery
Date: June 4 2002
20c. Location - City or Town, State: Monogahela, PA

21. Signature of Funeral Service Licensee: K Simons
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — 5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D34539
29d. Date signed (Month, Day, Year): 5.30.02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KHALID M. HUSAIN, MD, 22576 MACARTHUR BOULEVARD, CALIFORNIA MD 20619

State Registrar

31. Date filed (Month, Day, Year): MAY 31 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18029

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
SANDRA K. HENEIN	MAY / 26 / 2002	0737 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-66-5274	1 ☐ M 2 ☒ F	53 Yrs.			NOV. 12, 1948	WEST VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	MONTGOMERY	GERMANTOWN	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
19601 CRYSTAL ROCK DRIVE, #12	20874	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE		SUPERVISOR, WASTE WATER TREATMENT MANAGEMENT	SANITATION WSSC

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JUDGE BOOKER	DOROTHY CAROLINA LEFTRIDGE BOOKER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SHAUN C. EARLY / SON	13361 DEMETRIAS WAY, GERMANTOWN, MARYLAND 20874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	RESURRECTION CEMETERY	MAY 31, 2002	CLINTON, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
LYDIA C. THORNTON JOHNSON MO0583	THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD (OME)	D15236	MAY 26, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL I. MARGOLIS, MD 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18030

James Hill

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James Henry Hill	May 20, 2002	6:16 AM

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Civista Medical Center	La Plata	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-12-4797	1☒M 2☐F	81 Yrs.			February 22, 1921	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Charles	Marbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Stuckey Road	20658	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Pulp Wood Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Hill	Hattie Mae Butler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Cynthia Hill Daughter	3525 Jay St., N.E. #203, Washington, D.C. 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King James Baptist Church	May 26, 2002	Grayton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M00668	Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian Head, Md. 20640

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Abdominal Tumor possible Cancer	
Due to (or as a consequence of):	b. Seizure disorder	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Severe thrombocytopenia	
Due to (or as a consequence of):	d. ESRD on HD	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Interstitial Lung Disease

Gout

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D-0053219	5/20/2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Zafar A. Ansari, MD 7-E Post Office Road Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ann Juanita Hayden	May 18, 2002	2:47 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-28-1666	1☐M 2☒F	69 Yrs.			November 5, 1932	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
25184 Old Three Notch Road	20636	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Ethyl Abell	Mary Louise Wood

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joseph Aloysius Hayden/Husband	P.O. Box 131 Hollywood, MD 20636

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. John's Cemetery	May 23, 2002	Hollywood, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael A. Gardiner Jr.	Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	hr.
Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Coronary Artery Dz	yrs
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D 0649	5-21-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James P. Jarboe 24035 Three Notch Road Hollywood, MD 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18032

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael James Hatcher
2. Date of Death: Month May, Day 8, Year 2002
3. Time of Death: 3:50P M
4a. Facility Name (If not institution, give street and number): 26735 Thompson Corner Road
4b. City, Town, or Location of Death: Mechanicsville
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-74-6533
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 2, 1959
9. Birthplace (State or Foreign Country): California

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 26735 Thompson Corner Road
10f. Zip Code: 20659
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lineman
16b. Kind of Business/Industry: Electric Company

17. Father's Name (First, Middle, Last): Arthur Joseph Hatcher, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Patricia Ann Stone

19a. Informant's Name/Relationship (Type, Print): Louise Anne Hatcher Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26735 Thompson Corner Rd Mechanicsville MD 20659

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens
Date: May 13 2002
20c. Location - City or Town, State: Leonardtown, MD

21. Signature of Funeral Service Licensee: Michael K Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, P.O. Box 270 Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic melanoma — Due to (or as a consequence of): — 4yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John F. Fenwick
29c. License number: DOR&D
29d. Date signed (Month, Day, Year): 5-11-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Fenwick M.D. St. Mary's Medical Arts Bldg. Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year): MAY 13 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18033

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Sarah	E.	Horton	May 3, 2002	2:50p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-42-3802	1☐ M 2☒ F	89 Yrs.			Feb. 23, 1913	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Virginia	Scott	Pamplin	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
P.O. Box 1158, Church Street	23958	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lloyd Miller	Maxine Maness

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
E. Faye Blanche (Daughter)	16203 Cannfield Drive, Laurel, Maryland 20707

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Robinette Cemetery	5/8/2002	Blackwater, Virginia

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
Mary Bizzo	M01114	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiopulmonary Failure	WA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	Congestive Heart Failure	days
Due to (or as a consequence of): c.	Coronary Artery Dz.	yrs.
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation
Chronic renal failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
James P. Jarboe M.D.	D 06419	5-6-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James P. Jarboe, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 07 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18034

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES THOMAS KAHL
2. Date of Death (Month, Dey, Year): MAY 16, 2002
3. Time of Death: 8:45 AM

4a Facility Name *(If not institution, give street end number)*: 125 N. SECOND STREET
4b. City, Town, or Location of Death: OAKLAND
4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 217-28-2365
6. Sex: 1☒M 2☐F
7. Age *(In yrs. lest birthday)*: 69 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 18 1932
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10a. Stete: MD
10b. County: GARRETT
10c. City, Town or Location: OAKLAND
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 125 N. SECOND STREET
10f. Zip Code: 21550
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes: 2754-2/56
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ENGINEER
16b. Kind of Business/Industry: STATE HIGHWAY

17. Father's Neme *(First, Middle, Lest)*: EDWARD KAHL
18. Mother's Name *(First, Middle, Maiden Surname)*: CARRIE MANN

19a. Informant's Name/Relationship *(Type, Print)*: HELEN KAHL - WIFE
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 125 N. SECOND ST. OAKLAND, MD 21550

20a. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: OMEGA CREMATORY
Date: 5/18/02
20c. Location - City or Town, State: MORGANTOWN, WV

21. Signature of Funeral Service Licensee: Robert M Durst M00167
22. Name and Address of Fecility: P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. atherosclerotic cardiovascular disease — 3 - 6 mo
Due to (or as a consequence of):
b. Diabetes mellitus, type II — yrs
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
c. Chronic renal failure — months
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an eutopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes cese referred to medical examiner? 1☐Yes 2☒No
26. Plece of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Donald Richter MD
29c. License number: D30035
29d. Date signed *(Month, Day, Yeer)*: 05/16/2002

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550

State Registrar

31. Date tiled *(Month, Day, Year)*: MAY 17 2002
32. Registrer's Signeture: Benna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6+1VA

Mary Ann Lockwood
02-2718-029
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 060702:ITEMS#23a,b,ptII,27 per ME 0808 ss

Certificate of Death

Reg. No. 2002 18035

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary Ann Lockwood	May 25 2002	6:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
922 Washington Avenue	Chestertown	Kent

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-70-3895	1☐ M 2☒ F	45 Yrs.			Feb. 27, 1957	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Kent	Chestertown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
922 B Washington Ave.	21620	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jack Lloyd	Polly Boyles

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Diane Dankanyin (daughter)	P.O. Box 241 Woodside, DEL. 19980

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Chesapeake Cremation Cntr.	5-29-02	Chester, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Adams Funeral & Memorial Care (M00982) 1000 Bestgate Rd. Annapolis, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. MYOCARDIAL FIBROSIS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

If FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SCHIZOPHRENIA; OBESITY

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	May 26, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 31 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Phyllis Louise Myers

2. Date of Death (Month, Day, Year): May 25, 2002

3. Time of Death: 8:45 aM

4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 178 - 16 - 3839

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 5, 1920

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Hollywood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 42580 Anne Ct.

10f. Zip Code: 20636

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Confectionist

16b. Kind of Business/Industry: Candy Company

17. Father's Name (First, Middle, Last): Charles Henry Jones

18. Mother's Name (First, Middle, Maiden Surname): Fannie Alverta Shaffer

19a. Informant's Name/Relationship (Type, Print): Joanne Louise Lauer - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 42580 Anne Ct. Hollywood, MD 20636

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery

Date: May 29, 2002

20c. Location - City or Town, State: York, Pennsylvania

21. Signature of Funeral Service Licensee: Michael R. Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma to Brain — Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Atrial Fibrillation
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D19917

29d. Date signed (Month, Day, Year): May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James C. Boyd M.D. Wildewood Shopping Center California, MD 20619

State Registrar

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18037

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patrick Henry Mason
2. Date of Death (Month, Day, Year): May 18, 2002
3. Time of Death: 8:15 a. M
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 214-42-2945
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17, 1945
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 41220 New Market Turner Road
10f. Zip Code: 20659
10g. Citizen of What Country?: U S A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): James Henry Mason
18. Mother's Name (First, Middle, Maiden Surname): Louise Bond

19a. Informant's Name/Relationship (Type, Print): Mary V. Boylen (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 60 Underwood Place, N.E., Washington, DC 20012

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Queen of Peace
Date: 5/22/2002
20c. Location - City or Town, State: Helen, Maryland

21. Signature of Funeral Service Licensee: Mary Boylen M01114
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial infarction — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Coronary Artery Disease — 7 years
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Lung Cancer With Brain Metastasis
Diabetes Mellitus
End Stage Renal Disease

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D 56096
29d. Date signed (Month, Day, Year): 5/19/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajbinder S. Gill, M.D. Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002
32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Milburn Miller
2. Date of Death: Month May, Day 15, Year 2002
3. Time of Death: 5:16 A M
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 213-22-1319
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 24 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 22815 Goddard Court #50
10f. Zip Code: 20650
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
16b. Kind of Business/Industry: County Government

17. Father's Name (First, Middle, Last): James Milburn Miller
18. Mother's Name (First, Middle, Maiden Surname): Charlotte Milburn

19a. Informant's Name/Relationship (Type, Print): Mary M. White Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21311 Bristol Ave., Lexington Park, MD 20653

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Mem Gardens
Date: May 20 2002
20c. Location - City or Town, State: Leonardtown MD

21. Signature of Funeral Service Licensee: R. Simms
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. HYPOTENSION — 3 DAYS
Due to (or as a consequence of): c. SEPSIS — 3 DAYS
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D58096
29d. Date signed (Month, Day, Year): 5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICIA S. GILL 24035, THREE NOTCH RD HOLLYWOOD MD 20636

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002
32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anthony Mack Moore	MAY 23 2002	4:20 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
243-23-2882	1 [X] M 2 [ ] F	39 Yrs.					11-06-1962	Durham, NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Odenton	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
166 Pine Goved RD	21113	US

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Manager	Housing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jaycee Moore	Peggie Mack

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Peggie Moore/ Mother	1913 Essex Rd. Durham, NC 27704

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Glennview Memorial	5/28/02	Durham, NC

21. Signature of Funeral Service Licensee: Allen J. Waddell

22. Name and Address of Facility: Ellis D. Jones & Sons FH
419 Dowd Street Durham, NC 2770

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Lung Cancer with Metastasis to Spine	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gunjan Vader	D0058192	May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gunjan Vador, MD 3060 Mitchellville Road #103 Bowie, MD 20716

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	Geneva B Yates

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Cecelia Nelson
2. Date of Death (Month, Day, Year): May 6, 2002
3. Time of Death: 11:20 AM
4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 214-36-3972
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 25, 1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 27242 Sandy Acres Lane
10f. Zip Code: 20659
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Joseph Parlee Countiss
18. Mother's Name (First, Middle, Maiden Surname): Henrietta Cecelia Nelson

19a. Informant's Name/Relationship (Type, Print): Martha C. Daniels - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6911 Groveton Dr. Clinton, MD 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery
Date: 05/10/2002
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Michael Kevin Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ESRD

Due to (or as a consequence of):
b. Metabolic Encephalopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DM

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A.D. Shah
29c. License number: D 47066
29d. Date signed (Month, Day, Year): 5-7-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.D. Shah St. Mary's Medical Arts Bldg. Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year): MAY 07 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2002 18041

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ernest Clifton Oldham, Sr.

2. Dete of Deeth: Month May, Dey 20, Year 2002

3. Time of Death: 0227

4a Fecility Neme *(If not institution, give street and number)*: Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Deeth: Cecil

Funeral Director

5. Social Security Number: 717-09-2658

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: March 20, 1918

9. Birthplace *(State or Foreign Country)*: Maryland

Usuet Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Earleville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 429 Cherry Grove Road

10f. Zip Code: 21919

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: World War II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assistant Chief Electrician

16b. Kind of Business/Industry: Electrical

17. Fether's Neme *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Sumame)*: Rebecca Oldham

19a. Informant's Name/Reletionship *(Type, Print)*: Leora Kennedy Oldham/ Spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 429 Cherry Grove Road, Earleville, Maryland 21919

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Bay View Cemetery

Date: May 23, 2002

20c. Location - City or Town, State: Bay View, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Crouch Funeral Home 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — days

Due to (or as a consequence of):

b. Alzheimer's demention — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of tnjury *(Month, Day Year)*

28b. Time of Injury M

28c. tnjury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowtedge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ MD

29c. License number: D45755

29d. Date signed *(Month, Day, Year)*: 05/20/2002

30. Name end Addrass of pars on who completed cause of death (Item 23e) (Type, Print): John Mulvey, MD 111 W. High Street, Suite 214 Elkton, Maryland 21921

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 2002

32. Registrer's Signature ▶ Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Meryland Department of Health end Mentel Hygiene. **Important: If item 27 le marked other than "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

10+1 VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Ruene Marcella Russell	May 15 2002	10:30P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-12-2154	1☐M 2☒F	82 Yrs.			October 1 1919	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Leonardtown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
22680 Cedar Lane Court Apt. 1301	20650	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Frank Norris	Madeline Devine

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Rosella Cave Daughter	5406 San Juan Dr., Clinton, Maryland 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sacred Heart Cemetery	May 18 2002	Hushwood, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. failure to thrive	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Advance Dementia	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A.D. Shah	D 47066	5.17.02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A.D. Shah, MD - St. Mary's Medical Arts Bldg., Leonardtown, MD 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 17 2002	[signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alfred Francis Russell
2. Date of Death (Month, Day, Year): May 5, 2002
3. Time of Death: 6:15 p. M
4a. Facility Name (If not institution, give street and number): 35604 Army Navy Drive
4b. City, Town, or Location of Death: Mechanicsville
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 216-36-9662
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 93 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 27, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Colton Point
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 20611 Waterloo Road
10f. Zip Code: 20626
10g. Citizen of What Country?: U S A

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farming
16b. Kind of Business/Industry: Farm

17. Father's Name (First, Middle, Last): Patrick Wellington Russell
18. Mother's Name (First, Middle, Maiden Surname): Mary Pauline Raley

19a. Informant's Name/Relationship (Type, Print): Helen Hynson (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24611 Blackistone Road, Hollywood, Maryland 20636

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart Cemetery
Date: 5/9/2002
20c. Location - City or Town, State: Bushwood, Maryland

21. Signature & Funeral Service License: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — Approximate Interval Between Onset and Death: 3 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Lung Disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) grandsons residence

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John Fenwick
29c. License number: D-01380
29d. Date signed (Month, Day, Year): 5/6/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Fenwick, M.D. Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year): MAY 07 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANGELO ORTIZ RAQUEDAN
2. Date of Death: Month 05 Day 23 Year 02
3. Time of Death: 05:56 A M
4a. Facility Name (If not institution, give street and number): BALTIMORE VA MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 610-62-1145
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 23, 1921
9. Birthplace (State or Foreign Country): Philippines

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1 XX Yes 2 ☐ No
10e. Street and Number: 152 Mill Creek Road, Apt. No. 1006
10f. Zip Code: 21903
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): Four Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Pantar Community School Philippines

17. Father's Name (First, Middle, Last): Catalino Raquedan
18. Mother's Name (First, Middle, Maiden Surname): Anastasia Ortiz

19a. Informant's Name/Relationship (Type, Print): Marilou Pascual (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 152 Mill Creek Rd., Apt. No. 1006, Perryville, MD 21903

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris & Co., Inc.
Date: 05/25/02
20c. Location - City or Town, State: West Chester, Pennsylvania

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.
22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MASSIVE MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bebvon K. Martin MD
29c. License number: P14653
29d. Date signed (Month, Day, Year): 05-23-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BEBVON K. MARTIN, M.D. 10 N. GREENE ST.

State Registrar

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18045

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bobby Thomas Riley

2. Date of Death: Month MAY Day 20 Year 2002

3. Time of Death: 2035 M

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 229-40-1672

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 6, 1934

9. Birthplace (State or Foreign Country): West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4533 Maple Dam Road

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): shipping supervisor

16b. Kind of Business/Industry: garment mfg.

17. Father's Name (First, Middle, Last): George Henry Riley

18. Mother's Name (First, Middle, Maiden Surname): Opel Shrader

19a. Informant's Name/Relationship (Type, Print): Darlene Riley - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4533 Maple Dam Road, Cambridge, MD 21613

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dorchester Memorial Park Date: 5/24/02

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: Kenneth R Thomas Jr.

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Coronary Syndrome — Approximate Interval Between Onset and Death: 30 min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiac Arrhythmia — 4 min

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael Faulkner MD

29c. License number: D26388

29d. Date signed (Month, Day, Year): MAY 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Faulkner MD 302 Collins Ave Hooper MD 21643

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002

32. Registrar's Signature: B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Arne

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Christian Menno Swarey	May 29, 2002	2:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8060 Beethoven Place	Charlotte Hall	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-50-9281	1☒M 2☐F	78 Yrs.			October 17, 1923	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Charles	Charlotte Hall	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8060 Beethoven Place	20622	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Leather Craftsman	Harness Shop

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Israel Z. Swarey	Gertrude Peachey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lydia S. Swarey - Wife	8060 Beethoven Place Charlotte Hall, MD 20622

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Fisher Cemetery	June 1, 2002	Mechanicsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael K. Gardiner	Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PULMONARY EDEMA	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): CONGESTIVE HEART FAILURE	6 months
	c. Due to (or as a consequence of): END STAGE RENAL DISEASE	2 yrs
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

OSTEOARTHRITIS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] M.D.	H0057228MD	5/31/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR STEPHEN P. CAFFERTY 13 SWEET DARES BEACH RD. PRINCE FREDERICK, MD. 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 31 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2002 18047

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ruth Ann Smith	May 17, 2002	7:08 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
24517 Ruff Ruff Lane	Hollywood	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
233-03-1549	1☐M 2☒F	85 Yrs.			August 25, 1916	Ohio

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24517 Ruff Ruff Lane	20636	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Supply Clerk	US Government Civil Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Loche Findlay	Theresa Elizabeth Dolle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patrick Smith, Jr. Son	2136 Park Drive Slidell LA 70458

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MD Veterans Cemetery	May 21 2002	Cheltenham Maryland

21. Signature of Funeral Service Licensee: K Simms

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. PO Box Leonardtown MD 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction (presumed) Due to (or as a consequence of):	immediate
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes mellitus, Hypercholesterolemia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Timothy Curly	MD-064606-L	17 May 02

30. Name and address of person who completed cause of death (Item 23) (Type, Print): Timothy Curly 1050 W. Perimeter Rd. Andrews AFB MD 20762

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Barbara S Smith

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural', or Items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2002 | 8048

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Hilda	Maria	Stark	May 16, 2002	3:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
289-34-5728	1☐ M 2☒ F	88 Yrs.			Sept. 17, 1913	Austria-Hungary

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	California	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23140 Cobblestone Lane	20619	Austria-Hungary

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Liaison Officer	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Hans Unger	Mathilde Pohle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Stark (Son)	23030 Piney Wood Circle, California, Maryland 20619

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Brinsfield-Echols	5/20/02	Charlotte Hall, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Mary Rizzo M01114	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Aspiration Pneumonia

Due to (or as a consequence of):

c. Dysphagia

Due to (or as a consequence of):

d. Stroke

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Ramesh Panwala MD	D55027	May 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Panwala, M.D. California, Maryland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Phyeician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Ruth	Eileen	Storm	May 3, 2002	6:40 p. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Nursing Center	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
364-07-7090	1☐M 2☒F	83 Yrs.			June 4, 1918	Michigan

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	California	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23140 Cobblestone Lane	20619	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Homemaker	Own Home

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
Louis	Larson	Ethyl	Wells

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Douglas S. Storm (Spouse)	23140 Cobblestone Lane, California, Maryland 20619

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Brinsfield-Echols	5/6/2002	Charlotte Hall, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] M01114	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. failure to thrive

Due to (or as a consequence of):
b. Advance Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Colon Ca

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A.D. Shah	D 47066	5-6-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A.D. Shah, M.D. Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 07 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18050

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Cecil Fleming Snyder
2. Date of Death — Month: May; Day: 13; Year: 2002
3. Time of Death: 11:00 PM
4a. Facility Name *(If not institution, give street and number)*: 678 Ben DeWitt Road
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 219-01-7140
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Date of Birth *(Month, Day, Year)*: Dec. 19, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Oakland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 678 Ben DeWitt Road
10f. Zip Code: 21550
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 11th
College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: Home Contracting

17. Fether's Name *(First, Middle, Last)*: Solomon S. Snyder
18. Mother's Name *(First, Middle, Maiden Sumame)*: Bertha Mae Fleming

19a. Informant's Name/Relationship *(Type, Print)*: Dwight Snyder/Son
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 6646 Garrett Highway, Oakland, Md. 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Wolfe Cemetery
Date: 5/17/02
20c. Location - City or Town, State: Oakland, Maryland

21. Signature of Funeral Service Licensee: Bradley A. Stewart
22. Name and Address of Facility: Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Dysrhythmia — immediate

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular Accident
Chronic Renal Failure
Diabetes Mellitus

23b. Did tobacco use contribute to the cauee of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Karl E. Schwalm MD
29c. License number: D27205
29d. Date signed *(Month, Day, Year)*: 5/14/02

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Karl E. Schwalm, M.D. 311 N. Fourth St Oakland, MD 21550

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 16 2002
32. Registrer's Signeture: Donna L. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Haalth and Mantal Hygiana.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requiras that tha death certificata be executed within 24 hours after death.
To the Funeral Director: Aftar this certificata has baan signed by tha attanding physician and completaly filled in by tha funaral director, page 2 should ba datached for usa as tha burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18051

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Meredith Douglas Snyder
2. Date of Death (Month, Day, Year): May 12, 2002
3. Time of Death: 1:10 p.M
4a. Facility Name (If not institution, give street and number): 229 Accident Garage Road
4b. City, Town, or Location of Death: Accident
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 213-24-5563
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 9, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Accident
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 229 Accident Garage Road
10f. Zip Code: 21520
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW 2
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Heavy Equipment Operator
16b. Kind of Business/Industry: Construction Coal Mining &

17. Father's Name (First, Middle, Last): Ellis E. Snyder
18. Mother's Name (First, Middle, Maiden Surname): Josephine Bernard

19a. Informant's Name/Relationship (Type, Print): Norma J. Snyder/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 Accident Garage Rd., Accident, MD 21520

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bittinger Cemetery, May 14,2002
20c. Location - City or Town, State: Bittinger, MD

21. Signature of Funeral Service Licensee: Dale Newman
22. Name and Address of Facility: Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery (Month, Day, Year)

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: P. Daniel Miller DO
29c. License number: H26154
29d. Date signed (Month, Day, Year): 5/13/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 69 Wolf Acres Drive Oakland MD 21550 P Daniel Miller DO

State Registrar

31. Date filed (Month, Day, Year): MAY 14 2002
32. Registrar's Signature: Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

8+1VA

ADH
THEODORE THURMAN
02-2712-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061202:ITEMS#23a,27,28a-f *Certificate of Death* per ME 6308 ss Reg. No. 2002 18052

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Theodore		Thurmon	MAY	25,	2002	1948 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BON SECOUR HOSPITAL	BALTIMORE CITY	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-38-5410	1☒M 2☐F	61 Yrs.					July 17,1940	Georgia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
501 Dolphin Street	21217-3015	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		Attendant	Gas Station

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
Ivory	M.	Thurmon	Arlonia	H.	Tillman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Steven Thurmon (Brother)	21994 Spring Valley Ct., Lexington Park, MD 20653

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Missionary Baptist	5/31/2002	Lexington Park, MD

21. Signature - Funeral Service Licensee	22. Name and Address of Facility
Edward N. Brinsfield, Jr. M00052	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☒Pending investigation 6☐Could not be determined	5-25-02	A M	1☐Yes 2☒No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
residence (found)	1923 Walbrook Avenue, (found) Baltimore, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. M. Titus	OCME	MAY 26, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 31 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18053

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Franklin Thompson
2. Date of Death (Month, Day, Year): May 22, 2002
3. Time of Death: 2:50 p. M
4a. Facility Name (If not institution, give street and number): 17660 Clark Road
4b. City, Town, or Location of Death: Piney Point
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-01-4397
6. Sex: 1 ■ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.5,1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Piney Point
10d. Inside City Limits: 1 ☐ Yes 2 ■ No
10e. Street and Number: 17660 Clark Road
10f. Zip Code: 20674
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ■ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 ☐ No
If Yes, Give Year or Dates: 1941 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ■ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steamfitter
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Richard Emmett Thompson
18. Mother's Name (First, Middle, Maiden Surname): Madge Irene Crowder

19a. Informant's Name/Relationship (Type, Print): Gregory B. Thompson / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17660 Clark Road, Piney Point, Maryland 20674

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Francis Xavier
Date: 05-24-2002
20c. Location - City or Town, State: St. George's Island, MD

21. Signature of Funeral Service Licensee: Peter Sutherland M01300
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER & METASTASIS — 1 MONTH.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

fF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: RGill MD
29c. License number: D 56096
29d. Date signed (Month, Day, Year): 5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rajbinder Gill, M.D. Hollywood, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18054

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Sue Ellen Tasker	May 15, 2002	6:30 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Dennett Rd Manor Nursing Home	Oakland	Garrett

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
234 46 6631	1☐M 2☒F	88 Yrs.			Aug 24 1913	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Preston	Terra Alta	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
409 Freeland Ave.	26764	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Registered Nursee	Medical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Riggleman	Daisey Rohrbaugh

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Darrell Tasker	175 Spruce St. Parsons, WV 26287

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Terra Alta Cemetery	May 17,2002	Terra Alta,WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Howard A. Burdock	David A. Burdock FH 710 Church St. Kitzmiller,Md 21538

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CORONARY VASCULAR Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial Infartion X2 past
Atrial Fibrillation
Chronic Renal Insufficiency

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown	
24a. Was an autopsy performed? 1☐Yes 2☑No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ P. Daniel Miller DO	H26154	5/16/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
P. Daniel Miller DO 69 Wolf Acres Drive Oakland MD 21550

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 16 2002	Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18055

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Melvin Aloysius Wathen, Jr.	May 18, 2002	5:00 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
24955 McIntosh Road	Hollywood,	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-76-8761	1☒ M 2☐ F	43 Yrs.			October 7, 1958	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24955 McIntosh Road	20636	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Heating / Air conditioning Technician	Board of Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Melvin Aloysius Wathen, Sr.	Mary Catherine Cross

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anne Marie Alvey - Fiancee	PO Box 834 24955 McIntosh Rd. Hollywood, MD 20636

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Charles Memorial Gardens	May 23, 2002	Leonardtown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael R. Gardiner	Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown, MD 20650

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinomatosis	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Urinary Bladder Cancer	yr +
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No	26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ James P. Jarboe M.D.	D0649	5-30-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James P. Jarboe M.D. 24035 Three Notch Rd. Hollywood, MD 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alicia Bernadette Wilson
2. Date of Death (Month, Day, Year): April 29, 2002
3. Time of Death: 18:57 M
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 493-60-7815
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 18, 1946
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 45994 Great Mills Court
10f. Zip Code: 20653
10g. Citizen of What Country?: U S A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Child Care Provider
16b. Kind of Business/Industry: Day Care

17. Father's Name (First, Middle, Last): Robert E. Wilson
18. Mother's Name (First, Middle, Maiden Surname): Alicia Elizabeth McMurry

19a. Informant's Name/Relationship (Type, Print): Chiquita A. Wilson (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653: 45994 Great MIlls Court #301A, Lexington Park, MD

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Brinsfield-Echols
Date: 5/2/2002
20c. Location - City or Town, State: Charlotte Hall, MD

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeal Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Probable Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D14285
29d. Date signed (Month, Day, Year): 5-2-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyd, M.D. Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year): MAY 3 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Ella Louise Wilson	May 23 2002	2:50 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1009 Calvert Road	Rising Sun	Cecil

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
226-46-2347	1☐ M 2☒ F	70 Yrs.			July 14, 1931	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Cecil	Rising Sun	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1009 Calvert Road	21911	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Secretary and Treasurer	Wilson Fuel Oil

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
A. Taze Barton	Ethel Lee Fletcher

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alden Wilson/ Spouse	1009 Calvert Road, Rising Sun, Maryland 21911

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Rose Bank Cemetery	May 27, 2002	Calvert, Maryland

21. Signature of Funeral Service Licensee: Robert E. Crouch

22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ovarian Cancer	6 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Joseph K. Weidner Jr MD	D44373	5/23/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph K. Weidner, Jr., MD 101 Colonial Way Rising Sun, Maryland 21911

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Barbara A Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jesse Leonard Westbrook

2. Date of Death: Month May Day 21 Year 2002

3. Time of Death: 1:46 A. M

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-28-8325

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 6, 1927

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5308 Spring Drive

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): grocer

16b. Kind of Business/Industry: retail

17. Father's Name (First, Middle, Last): John Leonard Westbrook

18. Mother's Name (First, Middle, Maiden Surname): Elsie Woolsey

19a. Informant's Name/Relationship (Type, Print): Philip L. Bradshaw - nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Crestview Lane, Salisbury, MD 21801

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dorchester Memorial Park

Date: 5/24/02

20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPOXEMIA (SEVERE) — DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PULMONARY INSUFFICIENCY — DAYS

Due to (or as a consequence of):

c. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature], MD.

29c. License number: D 18551

29d. Date signed (Month, Day, Year): 5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMIR NGIMAT, MD. 7610 CARROLL AV. TAKOMA PARK, MD, 20912

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Joseph	Elmer	Young	MAY	21	2002	8:45 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-16-4291	1 M 2 F	93 Yrs.			April 17,1909	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Hollywood	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23986 Hollywood Road	20636	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		Heavy equipment operator	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Columbus Young	Sarah Stevens

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Agnes Marie Young / Wife	23986 Hollywood Road, Hollywood, Maryland 20636

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	St. John's Cemetery	5-25-2002	Hollywood, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Edward N. Brinsfield, Jr. M00052	Brinsfield Funeral Home, P.A. 22955 Hollywood Road,Leonardtown, MD 20650-0279

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	7DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. INTESTINAL OBSTRUCTION	10DAYS
	Due to (or as a consequence of): c. COLITIS	10 DAYS.
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COLONARY ARTERY DISEASE

DEMENTIA.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
MD	D56046	5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. RAJBINDER GILL PHILIP J.BEAN HOLLYWOOD.MD 20636

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
MAY 29 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then 'natural', or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: JOSEPH ELMER YOUNG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Robert Paul Yeatman	May 5, 2002	8:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
44809 Four Oaks Lane	California	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-34-1575	1 [X] M 2 [ ] F	66 Yrs.			Feb. 2, 1936	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	California	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
44809 Four Oaks Lane	20619	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Electronic Technician	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Paul Lennox Yeatman	Louise Lucine Bose

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Todd Robert Yeatman Son	18553 St. Jeromes Neck Road Dameron MD 20628

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Charles Memorial Gard.	5/8/02	Leonardtown Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael K. Gardiner	Mattingley-Gardiner Funeral Home, P.A. PO Box 270 Leonardtown MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Suspected Ventricular Arrhythmia — 1 day

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
David M. Federle MD	D34198	5/7/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David M. Federle 24035 Three Notch Road Hollywood MD 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 07 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18061

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Bernard George Alexander	June 2, 2002	6:16P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mercy Medical Center	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
n/a	1 ☒ M 2 ☐ F	Yrs.		1 / 49	June 2, 2002	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Middle River	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
515 Middle River Road	21220	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		n/a	n/a

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George William Alexander	Victoria Lynn Witt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
George William Alexander (Father)	515 Middle River Road, Baltimore, Maryland 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Oak Lawn Cemetery	June 6, 2002	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe Prematurity

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chorioamniotis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Nancy Brown-Holt MD	D41584	June 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy Brown-Holt, MD 301 St. Paul Place Baltimore, Maryland 21202

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Geneva B. Sparks

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached or used as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vincent George Alexander
2. Date of Death (Month, Day, Year): June 2, 2002
3. Time of Death: 6:15 PM
4a. Facility Name (If not institution, give street and number): Mercy Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: n/a
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours: 2 / Min.: 5
8. Date of Birth (Month, Day, Year): June 2, 2002
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 515 Middle River Road
10f. Zip Code: 21220
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): George William Alexander
18. Mother's Name (First, Middle, Maiden Surname): Victoria Lynn Witt

19a. Informant's Name/Relationship (Type, Print): George William Alexander (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 515 Middle River Road, Baltimore, Maryland 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: June 6, 2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Severe Prematurity
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Chorioamnionitis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nancy Brown-Holt, MD
29c. License number: D41584
29d. Date signed (Month, Day, Year): June 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nancy Brown-Holt, MD 301 St. Paul Place Baltimore, Maryland 21202

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

02-2901-033
B.K.S
BRIANNA ATKINSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITM #18 PER INF. G810 8/07/02 JH

1- For State Registrar UNPEND ITEMS #23,27,&28a-f PER ME. G809 7/15/02 JH

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2002 18063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Brianna Micah Atkinson
2. Date of Death (Month, Day, Year): JUNE 01, 2002
3. Time of Death: 8:23 A M
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 217-63-4826
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months 1 Days 18
If Under 24 Hrs.: Hours Min.
8. Date of Birth (Month, Day, Year): 04-14-02
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6884 Walker Mill Rd.
10f. Zip Code: 20743
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): n/a
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): Michael Atkinson
18. Mother's Name (First, Middle, Maiden Surname): ~~Carolyn Greene~~ CHRISTINA ROSS

19a. Informant's Name/Relationship (Type, Print): Michael Atkinson/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1302 Kings Valley Drive Bowie, MD 20716

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet
Date: 06-07-02
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SUDDEN UNEXPLAINED DEATH IN INFANCY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

If FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Date of Injury (Month, Day Year): found 6-1-02
28b. Time of Injury: found 7:26am M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND AT HOME
28f. Location (Street and Number or Rural Route Number, City or Town, State): DISTRICT HEIGHTS MD. 6304 WALKER MILL RD. #103

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JUNE 2, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Knows about pending 2

Albert Frank Arkuszewski, Jr.
02-2897-510
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 061102: ITEMS#23a,27 per ME 6808 ss

Reg. No. 2002 18064

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert F. Arkuszewski, Jr.

2. Date of Death: Month June, Day 02, Year 2002

3. Time of Death: 6:49 A M

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218 74 3876

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months, Days

If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): July 4, 1958

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 12 Second Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Material Analysts

16b. Kind of Business/Industry: OMEDIA

17. Father's Name (First, Middle, Last): Albert Arkuszewski Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary G. Dyer

19a. Informant's Name/Relationship (Type, Print): Albert Arkuszewski, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Second Avenue Baltimore, Maryland 21225

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 6/6/2002

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jerome Francowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. T.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): June 02, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002

32. Registrar's Signature: Jennifer D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18065

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
ELRAY	BARBER	06 / 02 / 2002	3:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MD STATE PENITENTIARY	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-94-3244	XX 1 M 2 F	37 Yrs.			8 23 65	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1117 N. Augusta Avenue	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		Nursing Asst.	Varies

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Johnny Montgomery	Lorraine Barber

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lorraine Barber Mother	2200 Park Avenue Apt. G-3 Balto. MD 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Woodlawn Cemetery	6-7-02	Woodlawn MD

21. Signature of Funeral Service Licensee: Kendra L. McFadden

22. Name and Address of Facility: BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E.NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. FLUID & ELECTROLYTE IMBALANCE	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CHRONIC DIARRHEA	
	Due to (or as a consequence of):	
	c. AIDS	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 X No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) PRISON

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): X 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Tedla Anbessie MD	D0046597	06/03/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TEDLA ANBESSIE, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	▶ Jennifer G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

James A. Burnette
CJ
02-2870-033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James A. Burnette

2. Date of Death: Month May, Day 31, Year 2002

3. Time of Death: 12:49 P.M

4a. Facility Name (If not institution, give street and number): 9821 Surratts Road

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-86-5249

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months, Days. If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): MAR 6, 1958

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9001 Ballard Lane

10f. Zip Code: 20735

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Refinisher

16b. Kind of Business/Industry: Auto Repair

17. Father's Name (First, Middle, Last): Walter B. Burnette

18. Mother's Name (First, Middle, Maiden Surname): Josephine Borrelli

19a. Informant's Name/Relationship (Type, Print): Richard A. Burnette/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 285 Beach Avenue Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 6-5-02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. GUNSHOT WOUND TO THE HEAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 5/31/02

28b. Time of Injury: 12:00 P.M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject shot himself

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Inside car on driveway

28f. Location (Street and Number or Rural Route Number, City or Town, State): 9821 Surratts Rd. Clinton, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): June 1, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ana Rubio, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002

32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Herman Burkman
2. Date of Death (Month, Day, Year): June 3, 2002
3. Time of Death: 5:10 PM M
4a. Facility Name (If not institution, give street and number): 4 Brookfield Road
4b. City, Town, or Location of Death: Pasadena
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-52-3924
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 24, 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4 Brookfield Road
10f. Zip Code: 21122
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Technician
16b. Kind of Business/Industry: Computer

17. Father's Name (First, Middle, Last): William H. Burkman
18. Mother's Name (First, Middle, Maiden Surname): Estelle Breeden

19a. Informant's Name/Relationship (Type, Print): Jefferson W. Burkman/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Brookfield Road Pasadena, MD 21122

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 6-5-02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: William P. Jones Deputy MD
29c. License number: D06054
29d. Date signed (Month, Day, Year): June 4, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

RR

RR 4

DHMH 17 Rev 1/2001

ORIGINAL

02-2923-510
mnmr
Jennifer Betz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18068

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Jennifer	L.	Betz	June	03,	2002	19:10 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-94-3377	1☐M 2☒F	22 Yrs.			March 31,1980	Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3001 Dunmurry Road	21222	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 yrs.		Teller	Bank

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Betz	Robin Grauling

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robin Leathers Mother	243 Hickory Ridge Rd.,Newport,Pa. 17074

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sacred Heart Of Jesus Cem.	June 7,2002	Dundalk,Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Anthony C. Connelly	Connelly Funeral Home Of Dundalk,P.A. 7110 Sollers Point Road, Dundalk,Md. 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aortic Encephalopathy Complicating Drug Intoxication	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	Found 6/1/02	unknown M	1☐Yes 2☒No	Subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
dwelling	unknown

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King M.D.	O.C.M.E.	June 04, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For Stete Registrar

Reg. No. 2002 18069

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria E. Brock
2. Date of Death Month/Day/Year: 6 - 5 - 02
3. Time of Death: 4:00 PM
4a. Facility Name (If not institution, give street and number): Manor Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-22-5006
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-24-20
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1346 Homestead St
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11th
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steam Presser
16b. Kind of Business/Industry: London Fog

17. Father's Name (First, Middle, Last): Jesse Edmonds
18. Mother's Name (First, Middle, Maiden Surname): Dallion Hawkins

19a. Informant's Name/Relationship (Type, Print): Carol Johnson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1346 Homstead st Balto MD 21218

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 6-12-02
20c. Location - City or Town, State: Maryland

21. Signature of Funeral Service Licensee: Patricia Betts
22. Name and Address of Facility: Betts Funeral Home 1129 N. Caroline st. Balto MD 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dehydration
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Sepsis
Due to (or as a consequence of):
c. UTI
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D56705
29d. Date signed (Month, Day, Year): 6/6/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RACHELLE GAJADHAR, 3007 E. NORTHERN PKWY, BALTIMORE MD 21214

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

RR

RR 3

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James Butler	MAY 30 2002	8:32 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Maryland General Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-60-9727	1☑M 2☐F	47 Yrs.			4-24-55	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
114 Parkin St	21201	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	N/A	Mail Clerk	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Butler	Ethel Mickey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vivian Royster	2416 Hollins Ferry Rd Balto MD 21211

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Green Mount Cemetery	6-3-02	Baltimore

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Patricia Betts	Betts Funeral Home 1129 N. Carolina st Balto MD 21213

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Acquired Immune Deficiency Syndrome

Due to (or as a consequence of):

c. Methicillin Resistant Staphylococcus Aureus

Due to (or as a consequence of):

d. Septicemia

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

End Stage Renal Disease

Cardiomegaly

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	P15705	5/30/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vasilios Pyrgos M.D. Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	▶

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMENDED ITEM#15 per fh G808 060602 **Certificate of Death** SS

Reg. No. 2002 18071

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
JAMES	BOONE		June 04 2002	1815 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-62-8567	1☒M 2☐F	47 Yrs.			11-4-54	Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
413 PATTERSON PARK AVE.	21231	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1974-1976	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	3 ~~Mth~~	Custodian	Aquarium

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES OLIVER BOONE, SR.	MARY MOSS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY BOONE / MOTHER	413 PATTERSON PARK AVE BALTO., MD. 21231

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CHERRYSON FOREST VA CEM	6/11/02	OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	BETTS FUNERAL HOME 1129 N. CHARLES ST - BALTO., MD 21213

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SUBDURAL HEMATOMA	3 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD, PHD	RES-000	JUNE 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID W. KACZKA, 600 N. WOLFE ST, BALTIMORE MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18072

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Polhamus Bonner	May 29, 2002	2:10 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Casey House	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
227-22-2204	1☐ M 2☒ F	77 Yrs.			Sept. 14, 1924	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Rockville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4602 Creek Shore Drive	20852	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates: XX	1☐ Yes 2☐ No Specify: XX	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	Computer Math Lab Aide	Elementary School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clinton Maynard Polhamus	Mary Joseph Fenton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Walter C. Bonnier, Jr./husband	4602 Creek Shore Drive, Rockville, MD 20852

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Baltimore Crematory at LP 5/31/02		Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Toni T. Holland	Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Chronic Obstructive Pulmonary Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	Home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Chitra Rajagopal	D42452	May 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Chitra Rajagopal 9715 Medical Center Drive Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Richard Scott Buchheim
02-2715-510
crn

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

UNPENDED 060702:ITEMS#23a,ptII,27,28a-f per ME G808 ss

Certificate of Death

Reg. No. 2002 18073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Scott Buchheim

2. Date of Death: Month May, Day 25, Year 2002

3. Time of Death: 11:56 P.M.

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-50-1035

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Nov. 18, 1947

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1101 N. Calvert St., Apt. #708

10f. Zip Code: 21214

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): New Project Director

16b. Kind of Business/Industry: Invent-Tech

17. Father's Neme (First, Middle, Last): Jack H. Buchheim

18. Mother's Name (First, Middle, Maiden Surname): Beatrice A. Oliver

19a. Informant's Name/Relationship (Type, Print): Elizabeth R. Schueler (Per Rep)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7733 Telegraph Rd., Lot 10, Severn, MD 21144

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Crematory @ Loudon Park

Date: 6/1/02

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☒ ~~Pending~~ investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year): Found: 5-25-02

28b. Time of Injury: Found: 11:15p M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1101 Calvert St., apt. 708, Balto., MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ ~~Medical Examiner~~: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. M. [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): May 26, 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): JACK M. TIROS, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HAMILTON CLARENCE BLACKSTONE SR.	JUNE 3 2002	0845 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
582 JONES ROAD	SEVERN	A.A.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
705-09-6763	1 [X] M 2 [ ] F	86 Yrs.			1-1-1916	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	A.A.	SEVERN	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
582 JONES RD.	21144	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		EMPLOYEE	PERKINS STATE HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HORACE BLACKSTONE	NEDA BLACKSTONE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BETTY SMALL(DAUGHTER)	582 JONES RD. SEVERN MD 21144

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	ARBUTUS MEM. PARK	11JUNE2002	ARBUTUS MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶E.N. WALKER JR	ESTEP BROTHERS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTIMORE MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Carcinoma of Prostate — 1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rajpinder Singh	D23341	6/05/02

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)
BHUPINDER SINGH MD 200 HOSPITAL DR #500 GLEN BURNIE 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	▶

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18075

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Blackwell

2. Date of Death Month June Day 3, Year 2002

3. Time of Death 2:58 A M

4a. Facility Name (If not institution, give street and number): University of Maryland Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 237-52-4253

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs/last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3-14-1937

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 906 PENNSYLVANIA AVE. APT.A

10f. Zip Code: 21201

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): CECIL BLACKWELL

18. Mother's Name (First, Middle, Maiden Surname): RUTH MOORE

19a. Informant's Name/Relationship (Type, Print): FELICIA ROSS(DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 410 W. FRANKLIN ST. BALTIMORE MD 21201

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY

Date: 5JUNE2002

20c. Location - City or Town, State: CATONSVILLE MD

21. Signature of Funeral Service Licensee: ▶ E.N.WALKER JR

22. Name and Address of Facility: ESTEP BROS. FUNERAL SERVICE P.A. 1300 EUTAW PL. BALTO. MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — Approximate Interval Between Onset and Death: weeks

Due to (or as a consequence of):

b. Dental Caries — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Stroke — months

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Aphasia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: P15842

29d. Date signed (Month, Day, Year): June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Adam Weinstein, 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18076

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
MELVIN	BROWN	May 31 2002	4:45 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Univ. of Maryland Medical Syst.	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-32-7344	1[X] M 2[ ] F	65 Yrs.			JUL 18, 1936	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	BALTIMORE	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3621 COTTAGE AVENUE	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates:	1[X] Yes 2[ ] No Specify:	Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th	0	HEAVY EQUIPMENT OPERATOR	STEEL CORPORATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNK	PEARL BROWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ANNA MARIE BROWN (WIFE)	3621 COTTAGE AVENUE BALTIMORE, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	KING MEMORIAL PARK	6/6/02	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Superior Vena Cava Syndrome — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Non Small Cell Lung Cancer — 5 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[X] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] Medicine Resident	P14670	June, 4 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCO J. PEREZ 22 S. Greene Street, Baltimore, Md 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

ADH
REDMOND DANTE CARR
02-2858-033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18077

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Redmond Dante Carr
2. Date of Death: Month MAY Day 31, Year 2002
3. Time of Death: 0101 A M
4a. Facility Name (If not institution, give street and number): 3833 26TH AVENUE
4b. City, Town, or Location of Death: OXON HILL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-11-8618
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 18 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 20, 1983
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3604-28th Parkway
10f. Zip Code: 20748
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): GED
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Kent Irving Carr
18. Mother's Name (First, Middle, Maiden Surname): Karen Vernell Jackson

19a. Informant's Name/Relationship (Type, Print): Mrs. Karen Carr (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3604-28th Parkway Temple Hills, Md. 20748

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Zion Hill Bapt Cem.
Date: 6/7/2002
20c. Location - City or Town, State: Cismont, Va.

21. Signature of Funeral Service License: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gunshot Wounds
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): 5/31/02
28b. Time of Injury: 0053HRS
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): grassy area
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3833 26th Avenue Oxon Hill, Maryland

29a. Certifier (Check only one)
1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kiyasu
29c. License number: OCME
29d. Date signed (Month, Day, Year): MAY 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore M. Kiyasu 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2002 18078

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARLTON FRANK CATLIN

2. Date of Death (Month, Day, Year): May 30, 2002

3. Time of Death: 7:00 PM

4a. Facility Name (If not institution, give street and number): Beverly Health Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-40-0737

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 15, 1921

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 30 North Place

10f. Zip Code: 21702

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): custodian

16b. Kind of Business/Industry: unk

17. Father's Neme (First, Middle, Last): Harry Catlin

18. Mother's Name (First, Middle, Maiden Surname): Ida Elizabeth Fleming

19a. Informant's Name/Relationship (Type, Print): Mary Catlin/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 30 North Place Frederick, MD 21702

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 5 DAYS

Due to (or as a consequence of):

b. Hypertension — 15 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Failure to Thrieve, Depression Neurogenic Bladder, Cachexic Immobility Syndrome, Parkinson.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year):

28b. Time of Injury M:

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rurel Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Allen Reilly MD

29c. License number: D54749

29d. Date signed (Month, Day, Year): 05 31 2002

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Allen Reilly, MD, 30 North Place, Frederick, MD 21701

State Registrar

31. Dete filed (Month, Day, Year): JUN 06 2002

32. Registrer's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

2002 18079 Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY E. CLAWSON
2. Date of Death: Month May Day 28, Year 2002
3. Time of Death: 1955 p M
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 578-34-3889
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-17-1922
9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 3655 DOLFIELD AVE.
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHERS AIDE
16b. Kind of Business/Industry: HEALTH CARE
17. Father's Name (First, Middle, Last): WILLIS BRINKLEY
18. Mother's Name (First, Middle, Maiden Surname): ANNIE COPPAGE
19a. Informant's Name/Relationship (Type, Print): WILLIS NICHOLSONNE / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4905 LOCHRAVEN BLVD. BALTO, MD 21218
20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 6-2-02
20c. Location - City or Town, State: BALTIMORE, MARYLAND
21. Signature of Funeral Service Licensee: Winfield Jordan M01015
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL HM 4905 YORK ROAD BALTIMORE, MD 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Approximate Interval Between Onset and Death: 2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Coronary Artery Disease — 20 Years
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Peter W. Cho MD
29c. License number: D41129
29d. Date signed (Month, Day, Year): May 29, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter W. Cho, MD Sinai Hospital of Baltimore, 5411 W. BELVEDERE AVE. BALTO, MD. 21215

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002
32. Registrar's Signature: Bonnie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item#19a,20b20c perFHG808 6/6/02 LW

AMEND ITEM#10d per fh G808 060602 ss

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2002 18080

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)	2. Dete of Death Month	Day	Year	3. Time of Death
Howard Cole	05	25	02	6:30 AM

4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Death
Delaney Towson	Towson	Baltimore

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. lest birthday)	If Under 1 Year Months	If Under 1 Year Deys	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
206-20-8832	1☒M 2☐F	71 Yrs.					10/25/1930	Nc.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
5133 Pembridge Ave.	21215	U.S.A.

11. Meritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Detes:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Loccal 192

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jessie Cole	Michelle Lillie Banks Raper

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Arthur ~~Author~~ Thomas	5133 Pembridge Ave. Baltimore, MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt Zion Cemetery ~~Kings Memoral Park~~	06/03/02	Balto. ~~Randallstown~~, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ E. M. Estep	Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, Md. 21217

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. End stage Renal Disease

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Prostate Carcinoma

Due to (or es a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did **tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Plece of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA	Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Attending Physician	D53662	May 27 2002

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)
XIAOZHE DA 3007 E. Northern Parkway Baltimore 21214

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signefure
JUN 06 2002	

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificete be executed within 24 hours after deeth.
To the Funeral Director: After this certificete has been signed by the etending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
HUBERT THEODORE CAREY	6/3/02	9:00 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOME 21 ELDERBERRY CT.	CATONSVILLE	BALTO.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219 32 9071	1☐M 2☐F X	64 Yrs.			2/21/38	MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	BALTO.	CATONSVILLE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
21 ELDERBERRY CT,	21228	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? / If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married X 3☐Widowed 4☐Divorced	1☒Yes 2☐No 9/59 6/62	1☐Yes 2☒No X Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	STEEL WORKER	BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN F. HARRISON	LUCINDA CAREY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SHIRLEY CAREY WIFE	21 ELDERBERRY CT. CATONSVILLE, MD. 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial X 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	GARRISON FOREST	5/12/02	OWINGS MILLS, MD,

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ C.A.ESTEP	ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Non small cell lung cancer	11months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] M.D.	D45530	06-05-2002

30. Name and address of person who completed cause of death (item 23a) (Type, Print)
SUITE 211, 8114 SANDPIPER CIRCLE, BALTIMORE, MD 21236

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	[signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18082

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris Edythe Davidson

2. Date of Death: Month June, Day 1, Year 2002

3. Time of Death: 12:50 AM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-14-4731

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): June 25, 1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2300 Dulaney Valley Rd.

10f. Zip Code: 21093

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12); College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Neme (First, Middle, Last): Birch A. Kailer

18. Mother's Name (First, Middle, Maiden Surname): Edith Marie French

19a. Informant's Name/Relationship (Type, Print): Anne Michaels/cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21 Hickory Ridge Ct. Baltimore, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 6/3/02

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee: John D. Mitchell IV

22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Lung Disease — yrs

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last:

b. Due to (or es e consequence of):

c. Due to (or as e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Generalized Atherosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D15504

29d. Date signed (Month, Day, Year): 6-7-02

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002

32. Registrer's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

12:50 A.M.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DORIS DAVIDSON JUNE 1, 2002

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Patricia A. Daniels
2. Date of Death: Month June Day 2 Year 2002
3. Time of Death: 7:42 AM
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-70-9857
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 11, 1958
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1019 E. Lake Ave.
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeping
16b. Kind of Business/Industry: Hotel

17. Father's Name (First, Middle, Last): Earl Stanback
18. Mother's Name (First, Middle, Maiden Surneme): Lillian E. Banks

19a. Informant's Name/Relationship (Type, Print): Anna Johnson - Sister
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 3663 Brenbrook Dr. Randallstown, MD 21133

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest V.A. | Date: 6-10-02
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gary P. March F/H P.A. 270 Fredhilton Pass Balto., MD 21229

Physician Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Adenocarcinoma	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cauae of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], Medical Doctor
29c. License number: RES-000
29d. Date signed (Month, Day, Year): June 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kweku Hayford, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Mary Dingle	May 31 2002	330 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-36-0042	1☐M 2☒F	65 Yrs.			2-2-37	S.Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9300 Tulsemere Rd.	21233	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Nurse Aide	Hospital

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Dennis Brown	Rosie Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty Whitford Daughter	9300 Tulsemere Rd, Baltimore, Md. 21233

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King Mem. Pk.	6-4--02	Randallstown, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Lloyd M. Estep	Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myelogenous Leukemia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	P14683	May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patrick List, MD University of Maryland Hospital

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	▶ Barbara B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18085

DEVRIES, LENA

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
LENA	DEVRIES	6 / 2 / 2002	5:45 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LEVINDALE HEBREW HOME	BALTIMORE	N/A

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-50-1481	1 ☐ M 2 ☒ F	92 Yrs.			AUG. 7, 1909	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	RANDALLSTOWN	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3530 RESOURCE DRIVE	21133	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ISAAC GOLDSTEIN	BESSIE (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROBERT GORDON / SON	15 CHARLES PLAZA #1503 - BALTIMORE, MD 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	BETH JACOB CEMETERY	6/5/02	FINKSBURG, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Peritonitis	3 days
Due to (or as a consequence of):	b. Bowel perforation	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Chronic Renal Insufficiency, Hypertension

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	033943	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Susan M Levy MD 2434 W Belvedere 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrer

Reg. No. 2002 18086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GARNETT M. DEWITT
2. Date of Death: Month June, Day 4, Year 2002
3. Time of Death: 10:55 a.m.
4a. Facility Name (If not institution, give street and number): Harbor Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-09-2399
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-10-1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Brooklyn Park
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 5600 Park Road
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: ABCD Industries

17. Father's Name (First, Middle, Last): Robert E. Moler
18. Mother's Name (First, Middle, Maiden Surname): Sophie Wolfe

19a. Informant's Name/Relationship (Type, Print): N.Earl Moler (Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1560 Marco Drive, Pasadena. Maryland 21222

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem Park
Date: 06-07-02
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave, Baltimore, Maryland 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Bacterial Meningitis — Approximate Interval Between Onset and Death: 2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Sepsis — 2 weeks
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes
Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kourosh Dibadj, M.D.
29c. License number: P14426
29d. Date signed (Month, Day, Year): June 4, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOUROSH DIBADJ, 3001 South Hanover Street, Harbor Hospital, Baltimore, Maryland 21225

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18087

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Madison Lynn Ey
2. Date of Death (Month, Day, Year): MAY 30, 2002
3. Time of Death: 2:55 P M
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours 2 / Min. 00
8. Date of Birth (Month, Day, Year): May 30, 2002
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: N/A
10b. County: N/A
10c. City, Town or Location: N/A
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: N/A
10f. Zip Code: N/A
10g. Citizen of What Country?: N/A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Eugene Brian Ey
18. Mother's Name (First, Middle, Maiden Surname): Lisa Janishefski

19a. Informant's Name/Relationship (Type, Print): Eugene B. Ey/father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Constant Ridge Ct. Abingdon, MD 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gard. Date: June 3, 2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: John O. Mitchell IV
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. EXTREME PREMATURITY — HOUR

Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): PRE VIABLE 21 WEEKS GESTATIONAL AGE
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? M 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nelson Davidson
29c. License number: D 36836
29d. Date signed (Month, Day, Year): 5/31/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NELSON DAVIDSON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
UNKNOWN 02-151
02-2696-510
Nicole S. Fleming

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

For State Registrar

UNPENDED 061002: ITEMS #23a, 27, 28a-f per ME 6808 ss

Reg. No. 2002 18088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Nicole S. Fleming	MAY 24, 2002	0940 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1600 MT. ROYAL AVENUE APT# 1211	BALTIMORE CITY	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-80-4600	1☐ M 2☒ F	29 Yrs.			10-28-72	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1917 DruidHill Avenue	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade		Waitress	TGI Friday

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ollie Fleming	Delores Goldstein

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Antonio Dickerson Brother	1103 E. Preston Street Baltimore MD 21202

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt Zion Cemetery	6-7-02	Lansdowne Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility BALTIMORE MARYLAND 21202
MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) ____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
Found: 5-24-02	Found: 7:30a M	1☐ Yes 2☒ No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): apartment

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1600 Mt. Royal Ave. apt. #1211, Balto., MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	OCME	MAY 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jack M. Titus, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 17 Rev 1/2001

ORIGINAL

Herbert Forrest
CJ
02-2611-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2002 18089

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert C. Forrest

2. Date of Death: Month May, Day 20, Year 2002

3. Time of Death: 01:59 P.M

4a. Facility Name (If not institution, give street and number): 501 Dolphin Street #810

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: Unknown

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1-4-29

9. Birthplace (State or Foreign Country): Baltimore, Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 501 Dolphin St.

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Business/Industry: Construction Co.

17. Father's Name (First, Middle, Last): Herbert Forrest

18. Mother's Name (First, Middle, Maiden Surname): Pauline Dorsey

19a. Informant's Name/Relationship (Type, Print): Michael Anderson Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 417 Edadale Rd, Baltimore, Maryland 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cem.

Date: 6-1-02

20c. Location - City or Town, State: Lansdrown, Md.

21. Signature of Funeral Service Licensee: Lloyd M. Estep

22. Name and Address of Facility: Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Stab and Cutting Wounds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): UNK

28b. Time of Injury: UNK M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject Stabbed and cut

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 501 Dolphin St. #810, 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawrence Locke MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): May 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Lawrence Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002

32. Registrar's Signature: Barbara B Spencer

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18090

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Anna Foy

2. Date of Death: Month June, Day 4, Year 2002

3. Time of Death: 10:00 A.M.

4a. Facility Name (If not institution, give street and number): 346 Washington Avenue

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 22 4087

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 14, 1923

9. Birthplace (State or Foreign Country): Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 346 Washington Avenue

10f. Zip Code: 21060

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Silk Screener

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): John Christopolus

18. Mother's Name (First, Middle, Maiden Surname): Sophia Smetnosky

19a. Informant's Name/Relationship (Type, Print): Rita Turc / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 346 Washington Avenue Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 6/7/02

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Donna M Zramiowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 10 years

Due to (or as a consequence of):
b. Arteriosclerotic Heart Disease — 15 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Renal Insufficiency

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Colvin Carter MD

29c. License number: D01549

29d. Date signed (Month, Day, Year): June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Colvin Carter 4710 Pennington Ave. Baltimore, Md. 21226

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002

32. Registrar's Signature: ▶ Barbara B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ADH
UNKNOWN 02-163
02-2861-510
ODELL GRIER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061802: ITEMS#23a,27,28a-f per ME G808 sss

Certificate of Death

Reg. No. 2002 18091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Odell Grier
2. Date of Death: Month MAY Day 31, Year 2002
3. Time of Death: 1401 P M
4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-84-3042
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 20, 1964
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2651 W. Lafayette Ave.
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Noxell Corporation

17. Father's Name (First, Middle, Last): Odell Jack Grier
18. Mother's Name (First, Middle, Maiden Surname): Shirley Grasty

19a. Informant's Name/Relationship (Type, Print): Mrs. Shirley Grier (mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2651 W. Lafayette Ave. Balto. Md. 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion
Date: 6/8/2002
20c. Location - City or Town, State: Lansdowne, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one) Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined
28a. Date of Injury (Month, Day Year): 5-31-02
28b. Time of Injury: Unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found: private dwelling
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2418 Etting St., Baltimore City, MD

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): JUNE 1, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2056.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace L. Gregory
2. Date of Death: Month June Day 1 Year 2002
3. Time of Death: 10:33 am
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-46-0967
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 29, 1947
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1006 St. Dunstans Rd.
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bus Driver
16b. Kind of Business/Industry: MTA

17. Father's Name (First, Middle, Last): Ernest L. Gregory SR.
18. Mother's Name (First, Middle, Maiden Surname): Grace E. Banks

19a. Informant's Name/Relationship (Type, Print): Vincent Cole - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1006 St. Dunstans Rd. Balto, MD 21229

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 6-7-02
20c. Location - City or Town, State: Lansdowne MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gary P. March Funeral Home, P.A. 270 Fredhilton Pass Balto, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Non Small Cell Lung cancer — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kweku Hayford, Medical Doctor
29c. License number: RES -000
29d. Date signed (Month, Day, Year): June 1, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kweku Hayford, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 217-87

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Norma	Faye	Gunther	June	4	2002	11:15p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8441 Bedford Road	Pasadena	Anne Arundel

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218 26 4791	1☐ M 2☒ F	70 Yrs.			Jan. 23, 1932	Tennessee

Funeral Director

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7722 West Shore Road	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Facility Engineer	Anne Arundel County School Board

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Huling	Ruby Pemberton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Karen Gunther / daughter	7722 West Shore Road Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Meadowridge Mem. Park	6/10/2002	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Branciforte

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	4 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Grandmother's Home

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gharnay M.D.	D39505	June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yudhish Markan, 1600 Crain Hwy, Glen Burnie, MD. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#20b per fh G808 060602 ss

Certificate of Death

Reg. No. 2002 18094

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LUCILLE HOLTMAN

2. Date of Death: Month MAY Dey 30 Yeer 2002

3. Time of Death: 1050 pm

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 217-38-1397

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 61 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 5, 1941

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1701 Kirk Road

10f. Zip Code: 21061

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Lest): Warren Taylor

18. Mother's Name (First, Middle, Maiden Surname): Lucille McGreevey

19a. Informant's Name/Relationship (Type, Print): Joseph T. Holtman-Son

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 9 Catonridge Court, Catonsville, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery | Date: 6-6-02

20c. Location - City or Town, State: 5-6-2002 Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Loudon Park Funeral Home 3620 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. RESPIRATORY ACIDOSIS — 1 DAY

Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Due to (or as a consequence of): RAPID ONSET DEMENTIA — 1 YEAR

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM

HYPERCHOLESTEROLEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: MD RESIDENT

29c. License number: P15582

29d. Date signed (Month, Day, Year): MAY 30, 2002

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): 3001 KEVIN M. AVOLIO, MD. 3001 SOUTH HANOVER STREET BALTIMORE, MARYLAND 21225

State Registrar

31. Dete filed (Month, Day, Year): JUN 0 6 2002

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

RR

RR 3

02-2789-510
SONIA HUDDLESTON
RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 062402: ITEMS#23a,27 per ME 6806 ss

Certificate of Death

Reg. No. 2002 18095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SONIA HUDDLESTON
2. Date of Death: Month MAY Day 29, Year 2002
3. Time of Death: 5:52A. M
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 035-54-2852
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 33 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-27-1968
9. Birthplace (State or Foreign Country): CONNECTICUT

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 27 N. EDEN STREET
10f. Zip Code: 21231
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 6
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name (First, Middle, Last): HARRY HUGULEY
18. Mother's Name (First, Middle, Maiden Surname): MARCILLIA FORD

19a. Informant's Name/Relationship (Type, Print): KENNEDY HUDDLESTON (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 N. EDEN ST. BALTO, MD. 21231

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING PARK CEMETERY
Date: 6/4/02
20c. Location - City or Town, State: BALTIMORE. MD

21. Signature of Funeral Service Licensee: Peter Winfield Jordan MD1015
22. Name and Address of Facility: VAUGHN GREENE FUNERAL SERVICE 4905 YORK ROAD. BALTO, MD. 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. AORTIC DISSECTION WITH AORTIC RUPTURE AND HEMOPERICARDIUM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Theodore M. Kling MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): MAY 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KLING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Penny D. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 9068.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18096

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rebecca Jane Higgins
2. Date of Death: Month: May; Day: 30; Year: 2002
3. Time of Death: 2:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: 407 Phelps Avenue
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 239 38 2180
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 8, 1931
9. Birthplace *(State or Foreign Country)*: North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 407 Phelps Avenue
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2 years
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Data Entry
16b. Kind of Business/Industry: State of Maryland

17. Father's Name *(First, Middle, Last)*: Mabry Curtis Coley
18. Mother's Name *(First, Middle, Maiden Surname)*: Nina E. Greene

19a. Informant's Name/Relationship *(Type, Print)*: Paul Higgins / Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 407 Phelps Avenue Glen Burnie, Maryland 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD State Veteran Cem.
Date: 6/3/02
20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Donna M Bramiowski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic Failure
Due to (or as a consequence of):
b. Cirrhosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Ascites

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D53462
29d. Date signed *(Month, Day, Year)*: 5/31/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jude Muneses MD 7845 Oakwood Road GlenBurnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 0 6 2002
32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18097

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WANDA JOHNSON
2. Date of Death (Month, Day, Year): MAY 24 2002
3. Time of Death: 2:29 PM
4a. Facility Name (If not institution, give street and number): MARYLAND GENERAL HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE City
4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-86-2526
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3 2 65
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 428 S. Loudon Avenue
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodial
16b. Kind of Business/Industry: Hilton Hotel

17. Father's Name (First, Middle, Last): Lawrence Johnson
18. Mother's Name (First, Middle, Maiden Surname): Bernice Simpson

19a. Informant's Name/Relationship (Type, Print): Tirzah Simpson Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4649 Manordene Road Apt. D Balto. MD 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT Carmel Cem.
Date: 6-1-02
20c. Location - City or Town, State: Dundalk Maryland

21. Signature of Funeral Service Licensee: ▶ Wanda Warner
22. Name and Address of Facility: BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. ANOXIC ENCEPHALOPATHY
Due to (or as a consequence of):
b. NECROTIC ULCERATION of the STOMACH with PERFORATION
Due to (or as a consequence of):
c. END STAGE RENAL DISEASE
Due to (or as a consequence of):
d. PERITONITIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: 1889
29d. Date signed (Month, Day, Year): 5/24/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VINCENT AGBARAJI M.D. MARYLAND GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Wanda Johnson
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18098

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month / Day / Year)	3. Time of Death
LEON J. JACKSON	June 1 2002	2126 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Agnes Healthcare	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-01-2117	X 1 M 2 F	81 Yrs.			1-5-1921	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
706 ALLENDALE ST.	21229	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		TRUCK DRIVER	DISTRIBUTING CO.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JAMES JACKSON	ANNIE E. JACKSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BARBARA LOMEX (NIECE)	3604 CALLOWAY AVE. BALTIMORE MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	MT. ZION CEMETERY	7JUNE2002	BALTO. CO MD

21. Signature of Funeral Service Licensee: ▶ E.N.WALKER JR

22. Name and Address of Facility: ESTEP BROTHERS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTO. MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Cardiovascular Heart Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Edana Mann	D0056092	June 1, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Edana Mann 900 Caton Avenue Baltimore Maryland 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	▶ James D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Medical Certification: To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Jackson, Leon J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18099

Patient known as: Jones, Willena

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLENA P. JONES

2. Date of Death: Month June Day 4 Year 2002

3. Time of Death: 1257 M

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 247-72-1953

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 2, 1941

9. Birthplace (State or Foreign Country): SC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6919 FIELDCREST ROAD

10f. Zip Code: 21215

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER

16b. Kind of Business/Industry: HOMES

17. Father's Name (First, Middle, Last): MCQUILLAR WILSON

18. Mother's Name (First, Middle, Maiden Surname): ISABELLE MCFADDEN

19a. Informant's Name/Relationship (Type, Print): MILDRED R. THOMAS (GRAND-DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6919 FIELDCREST ROAD BALTIMORE, MD 21215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY

Date: 6/8/02

20c. Location - City or Town, State: GLEN BURNIE, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21215

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Overwhelming Gastrointestinal Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Cancer, primary unknown

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James E. Stone, MD

29c. License number: Res-000

29d. Date signed (Month, Day, Year): June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James E. Stone, MD Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18100

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sharon Keesling
2. Date of Death (Month, Day, Year): June 3, 2002
3. Time of Death: 8:04 p M
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-68-4139
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB 19, 1955
9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7716 Dew Wood Drive
10f. Zip Code: 20855
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager
16b. Kind of Business/Industry: Statistical Research

17. Father's Name (First, Middle, Last): Peter Rutledge Keesling
18. Mother's Name (First, Middle, Maiden Surname): Patricia Ruth Miller

19a. Informant's Name/Relationship (Type, Print): Dennis J. Smith/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7716 Dew Wood Drive Derwood, MD 20855

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 6-6-02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Head injuries with Complications

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

CLARIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☑ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 6/2/02
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject fell
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7716 Dewwood Drive Rockville Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Nathaniel McQuay, Jr.
29c. License number: P14152
29d. Date signed (Month, Dey, Year): June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nathaniel McQuay Jr, 22 South Greene St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Russell Kelly

2. Dete of Deeth — Month: June; Dey: 5; Year: 2002

3. Time of Death: 5:10 am

4e. Fecility Name (If not institution, give street end number): Gilchrist Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 357 09 1470

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. lest birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 9, 1924

9. Birthplace (State or Foreign Country): Illinois

Usuel Residence of Decedent

10a. State: FL

10b. County: Hillsborough

10c. City, Town or Location: Tampa

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street end Number: 4532 West Kennedy Boulevard

10f. Zip Code: 33609

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII

13. Was Dacedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): — College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mediator

16b. Kind of Business/Industry: County Circuit Court

17. Fether's Name (First, Middle, Last): Peter Leroy Kelly

18. Mother's Name (First, Middle, Maiden Sumame): Pearl Chafey

19a. Informant's Name/Relationship (Type, Print): Maureen Kelly-Ostrosky/Daughter

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 7009 Bright Memory Drive Columbia, MD 21044

20e. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 6-6-2002

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: Tom Collins - atty — M01044

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat diseese or condition resulting in death): e. colon cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and ptace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Helen M. Gordon

29c. License number: D0051926

29d. Date signed (Month, Day, Yeer): June 5, 2002

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Helen M. Gordon 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Dete filed (Month, Day, Year): JUN 06 2002

32. Registrer's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

James Kelly June 5, 2002 0510A

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18102

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ETHEL KIRSCHMAN
2. Date of Death Month Day Year: JUNE 1, 2002
3. Time of Death: 2:40 PM
4e. Facility Name *(If not institution, give street and number)*: 28 WOODHOLME AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-26-5229
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV.6,1906
9. Birthplace *(State or Foreign Country)*: MICHIGAN

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 28 WOODHOLME AVENUE
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: ABRAHAM JOSEPH RUBINER
18. Mother's Name *(First, Middle, Maiden Surname)*: MIRIAM SCHETZER

19a. Informant's Name/Relationship *(Type, Print)*: MARY JO KIRSCHMAN / DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2901 OVERLAND AVENUE - BALTIMORE, MD 21214

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BALTIMORE HEBREW CEMETERY
Date: 6/5/02
20c. Location - City or Town, State: REISTERSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Chronic Obstructive Pulmonary Disease — 4yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Debra Wertheimer MD
29c. License number: D23767
29d. Date signed *(Month, Day, Year)*: June 3, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Debra Wertheimer MD, 2434 W. Belvedere Ave, Balto., MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18103

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
DONALD	KNICK	05	31	2002	8:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical System	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-66-3132	XX M 2 F	47 Yrs.			Sept. 23, 1954	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Edgemere	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2400 Lincoln Avenue Lot 30	21219	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 Years		Punch-Out Man	Ryland Homes

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Clayton Knick	Norma Laughery

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Willard Knick (Brother)	7020 Bank Street Baltimore, Maryland 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Holly Hill Mem. Gdns.	6/4/2002	Middle River, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No	26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined				

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	G-13791	5/31/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kristen G. Hairston 22 South Greene street Baltimore MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18104

KASEY, GERALDINE
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GERALDINE KASEY
2. Date of Death: Month May Day 31 Year 2002
3. Time of Death: 11:00 PM
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 213-90-3626
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 25, 1963
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 533 BLOOM ST.
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNEMPLOYED
16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): MACK KASEY
18. Mother's Name (First, Middle, Maiden Surname): MARY I. HAYMAN

19a. Informant's Name/Relationship (Type, Print): SHANTA NICHOLSON/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 630 N. Carey St. Baltimore, Md 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY
Date: 6-6-02
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: WILLIAM C. BROWN COMMUNITY FUNERAL HOME 1206 W. North Ave.

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis
Due to (or as a consequence of): b. Pneumonia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. AIDS
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] (MD)
29c. License number: P89450
29d. Date signed (Month, Day, Year): May 31, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Reynaldo Lee-Llacer, MD, c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #23b PER PHY G808 6/06/02 JH

Certificate of Death

Reg. No. 2002 18105

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Edward Arthur Lenz	May 25 2002	08:25 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St Mary's Hospital	Leonardstown	St Mary's County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
186 24 4898	1☐M 2☐F	79 Yrs.			September 14 1922	Cylinder, Iowa

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Joppa	1☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
506 Anchor Drive	21085	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW II	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	NA	Salesman	Ed Lenz Enterprises, Inc

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Adolph Lenz	Florentina Richter

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley M. Lenz (Wife)	506 Anchor Drive Joppa, Maryland 21085

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) / Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Immanuel Lutheran Cem. May 30, 2002	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Heather Jessain Chgrodi	Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Distress Syndrome	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PNUEMONIA	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

dhl 23a

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

(a) Pneumonia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown	
24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ SC Gaby M.D.	D54346	5/25/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRA SAJJA M.D. PHILIP J.BEAN MEDICAL CENTER HOLLYWOOD,MD. 20636

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Sandra B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

EDWARD ARTHUR LENZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #19b PER INF. G808 6/11/02 JH **Certificate of Death** Reg. No. 2002 18106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELVIRA BROWN LOMBARDO
2. Dete of Deeth: Month June, Dey 4, Year 2002
3. Time of Death: 12:50 A.M.
4a Fecility Neme (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Deeth: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-40-7611
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 100 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 13, 1901
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2300 Dulaney Valley Road
10f. Zip Code: 21093
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): James H. Brown
18. Mother's Name (First, Middle, Maiden Surname): Gwinetta Lee Cox

19a. Informant's Name/Relationship (Type, Print): John E. Lombardo (son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~13~~ 1301 One Smeton Place Towson, Maryland 21204

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Cemetery
Date: 6-7-02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: George J. Fenaun
22. Name and Address of Fecility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Squamous Cell Carcinoma of Skin

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D43725
29d. Date signed (Month, Day, Year): 6/4/02

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): TARIQ MAHMOOD, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

State Registrar

31. Dete filed (Month, Day, Year): JUN 0 6 2002
32. Registrer's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ELVIRA LOMBARDO JUNE 4, 2002 12:50 A.M.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18107

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Spencer Everett Lawson	May 24, 2002	0200 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Shady Grove Adventist Hospital	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-20-2140	XX 1 M 2 F	76 Yrs.			August 11, 1925	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Rockville	1 Yes X 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
743 Anderson Avenue	20850	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates: 1942-45	1 Yes 2 XX No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		General Contractor	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Spencer Lawson	Virginia Lawson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Violet Lawson/wife	743 Anderson Avenue, Rockville, MD 20850

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Baltimore Crematory at LP	5/28/02	Baltimore, MD

21. Signature of Funeral Service Licensee: Toni T. Holland

22. Name and Address of Facility: Simple Tribute Funeral and Cremation Center 1040 Rockville Pike Rockville, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Septic Shock	24 hours
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acute respiratory failure	
	Due to (or as a consequence of):	
	c. Pneumonia	
	Due to (or as a consequence of):	
	d. Acute and Chronic Cardiac Arythemia	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Hemorrhage

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 Yes 2 X No	Hospital: XX 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): XX 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Hien D. Khaney	D22978	May 24, 20002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Hien Khanely, 19520 Doctors Drive, Germantown, MD 20874

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	Jeanne B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18108

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie I. Logan-N'Diaye
2. Date of Death (Month, Day, Year): May 23, 2002
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 403-54-4390
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept.15,1939
9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9012 Bramble Bush Court
10f. Zip Code: 20879
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Safeway Food Stores

17. Father's Name (First, Middle, Last): Louis Britt
18. Mother's Name (First, Middle, Maiden Surname): Mariah Moss

19a. Informant's Name/Relationship (Type, Print): TuJuannia Britt/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9012 Bramble Bush Court; Gaithersburg, MD 20879

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven
Date: 05/31/2002
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Anthony L. Dorsey
22. Name and Address of Facility: Simple Tribute Funeral & Cremation Center 1040 Rockville Pike; Rockville, MD 20852

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Adult Respiratory Distress Syndrome — Approximate Interval Between Onset and Death: Days

Due to (or as a consequence of):
b. Congestive Heart Failure — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Type II Diabetes — Years

Due to (or as a consequence of):
d. Coronary Artery Disease — Years

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Abulfarag, MD
29c. License number: D 31391
29d. Date signed (Month, Day, Year): May 25 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sudhair Abulfarag, MD 481 N. Frederick Ave. #230 Gaithersburg, MD 20872

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Bonnie B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

02-2918-510
B.K.S
PATRICIA LYNN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 062002: ITEMS#23a,27 per ME Code SS

Certificate of Death

Reg. No. 2002 18109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
PATRICIA	LYNN		JUNE	3,	2002	0825 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2822 BOOKERT DRIVE	BALTIMORE	N-A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-44-8737	1☐M 2☒F	55 Yrs.					FEB.1,1947	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2822 BOOKERT DRIVE	21225	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SEAMSTRESS	INDUSTRIAL SEWING FACTORIES

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALONZO LYNN	LIZZIE LYNN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SHERMA BUSHROD(SISTER)	1306 PENNSYLVANIA AVE. BALTIMORE MD 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	METRO CREMATORY 5	JUNE 2002	CATONSVILLE MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
E.N. WALKER JR	ESTEP BROTHERS FUNERAL SERVICE P.A. 1300 EUTAW PLACE BALTO. MD 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COMPLICATIONS OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

25. Was case relerred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E	JUNE 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip H. LANDAU
2. Date of Death: Month May Day 31 Year 2002
3. Time of Death: 0354 AM

4a. Facility Name (If not institution, give street and number): Howard County General Hospital
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 085-03-7761
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 2, 1918
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No
10e. Street and Number: 6336 Cedar Lane
10f. Zip Code: 21044
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): Philip Henry Landau
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Brandon Hunt

19a. Informant's Name/Relationship (Type, Print): Ms. Deborah Weimer Step-child
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6203 Elmbank Ave. Baltimore, Maryland 21209

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): All County Cremation Services, Inc.
Date: 06/03/2002
20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Melody M Slacker MD1293
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Amphysema — Due to (or as a consequence of): — Acute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Arterial Disease — Due to (or as a consequence of): — yrs
c. Cerebral vascular Disease — Due to (or as a consequence of): — yrs
d. — Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Aortic insufficiency

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MA
29c. License number: D-34868
29d. Date signed (Month, Day, Year): May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S Diener MOST Little Patuxent Plz Columbia MD 21044

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Bonnie B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #4b PER PHY G808 6/06/02 JH

Reg. No. 2002 18111

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
EDITH MOSBACHER	JUNE 02 2002	12:07PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL	RANDALLSTOWN ~~BALTIMORE~~	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-12-6599	1☐M 2☒F	78 Yrs.			FEB 12 1924	GERMANY

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
130 SLADE AVE #223	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		OWNER/OPERATOR	GROCERY STORE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HUGO BENDORF	SELMA WARTENSLEBEN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. MITCHELL MOSBACHER/SON	6646 ECHO VALLEY MAUMEE OHIO 43537

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory, or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CHEVRA AHAVAS CHESED	6/4/2002	RANDALLSTOWN,MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward C. Rund	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS	2 wk.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): PNEUMONIA	2 wk.
	c. Due to (or as a consequence of): CONGESTIVE HEART FAILURE	2 wk.
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 0055481	JUNE 02 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAWE GLAUB 5401 OLD COURT ROAD RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

02-2874-510 Juanita Meadows
B.K.S
UNKNOWN 02-164

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JUANITA MEADOWS
2. Date of Death (Month, Day, Year): JUNE 1, 2002
3. Time of Death: 0325 AM
4a. Facility Name (If not institution, give street and number): 2500 WILKINS AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-06-4571
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 17 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11 9 84
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 2700 Wilkens Avenue
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: NA

17. Father's Name (First, Middle, Last): Stanley Franklin
18. Mother's Name (First, Middle, Maiden Surname): Terry R. Meadows

19a. Informant's Name/Relationship (Type, Print): Terry R. Meadows Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2700 Wilkens Avenue Baltimore MD 21223

20a. Method of Disposition: ☒ 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt Zion Cemetery
Date: 6-7-02
20c. Location - City or Town, State: Lansdowne MD

21. Signature of Funeral Service Licensee: Andrae L McFadden
22. Name and Address of Facility: BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gunshot wound to back

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence ☒ Other (Specify) AT SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): 6/1/02
28b. Time of Injury: A. M.
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: SUBJECT WAS SHOT
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2500 BLK WILKENS, BALTIMORE, MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JUNE 1, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pamela Suzanne Meyer
2. Date of Death (Month, Day, Year): June 4, 2002
3. Time of Death: 3:30 PM
4a. Facility Name (If not institution, give street and number): 1025 S. Curley Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 056-36-6132
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 10, 1940
9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1025 S. Curley Street
10f. Zip Code: 21224
10g. Citizen of What Country: England

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrative Secretary
16b. Kind of Business/Industry: Nonprofit Church Organization

17. Father's Name (First, Middle, Last): Albert Jeeves
18. Mother's Name (First, Middle, Maiden Surname): Phyllis Atkinson

19a. Informant's Name/Relationship (Type, Print): Suzanne A. Circosta /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1025 S. Curley Street, Baltimore, MD 21224

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc. | Date: 6/5/02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MALIGNANT FIBROUS HISTIOCYTOMA — 6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
SEVERE RENAL ARTERY STENOSIS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: 038409
29d. Date signed (Month, Day, Year): June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Sharrow 10753 Falls Rd #415, Bolt, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18114

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Neptali Lugo	June 4, 2002	3:00 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Kris-Leigh Assisted Living	Odenton	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
366-30-8027	1☐M 2☐F	79 Yrs.			SEPT 16, 1922	Puerto Rico

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Odenton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1032 Annapolis Road	21054	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates:	1☒Yes 2☐No Specify: Puerto Rican	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Supply Sergeant	U S Army

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Juan Lugo	Maria UNK.

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Peter Lugo/Son	312 Lori Drive Glen Burnie, MD 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory Inc.	6-5-02	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Thomas Gregor	Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cancer of pancreas, metastatic and recurrent	3 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

None

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Assisted Living

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
William Hunter MD	D43789	June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM HUNTER MD 13960 Baltimore Blvd. Laurel, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

RF

RR 6

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
Rose	Louise	Bertuca	Matejevich	May 31, 2002	3:45 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Elizabeth Nursing Center	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
185-14-5277	1☐ M 2☒ F	79 Yrs.			Oct. 29, 1922	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3310 Benson Ave	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Assembly Line Worker	Westinghouse

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Sebastian Bertuca	Angelina Laurie

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mike R. Matejevich (Son)	1 Vale Rd., Suite 200, Bel Air, MD 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Loudon Park Cemetery	6/4/02	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Breast Cancer — 1 Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

RR

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D-55391	May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ming Yi 3320 Benson Ave., Baltimore, MD 21227

RR 10

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2747-510
mnmr
Alton Moore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 060702: ITEMS#23a,27,28a-f per ME case ss

Reg. No. 2002 18116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ALTON T. MOORE	May 27, 2002	19:45 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Good Samaritan Hospital	Baltimore	N/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-68-2837	1 ☑ M 2 ☐ F	45 Yrs.			12-28-1957	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		BALTIMORE	1 ☑ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5405 LOTHIAN ROAD	21212	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	MECHANIC	INDUSTRIAL MAINTENANC
12			

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
BURNA H MOORE	MINNIE WILLIAMS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MINNIE MOORE / MOTHER	5405 LOTHIAN ROAD BALTIMORE, MD 21212

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	GARRISON VA Cemetery	6-4-02	OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
MD1015	VAUGHN C. GREENE FUNERAL HOME
	4905 YORK ROAD BALTIMORE, MD 21212

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEROIN AND COCAINE INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No	1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☒ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined	Found: May 27, 2002	Found: 7:45p M	1 ☐ Yes 2 ☒ No	Unknown
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Unknown			Unknown

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 ☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Benjamin D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
WOLFGANG	MEYER	June 4 2002	3:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
023-16-4861	1 [X] M 2 [ ] F	92 Yrs.			DEC 4, 1909	GERMANY

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6001 PARK HEIGHTS AVE., APT. 3-C	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		FOREMAN	SCRAP METAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
NATHAN MEYER	SARA MOLLER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. MIRIAM MEYER (WIFE)	6001 PARK HEIGHTS AVE., APT. 3-C BALTO., MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	CHEVRA AHAVAS CHESED	6/5/02	RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Michael Krugen

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
David S. Lee MD	RES-000	June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David S. Lee, MD Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Donna B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

PATIENT KNOWNAS MEYER, WOLFGANG.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 | 8 | 18

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PORT A. LARGENT
2. Date of Death (Month, Day, Year): JUNE 03 2002
3. Time of Death: 10:15 PM
4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE HAMMONDS LANE
4b. City, Town, or Location of Death: BROOKLYN PARK
4c. County of Death: ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number: 705-09-9661
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 97 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 08-18-1904
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Brooklyn Park
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 915 Hammonds Lane
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 9
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter
16b. Kind of Business/Industry: Joseph Seagrams Co.

17. Father's Name (First, Middle, Last): Jerry Largent
18. Mother's Name (First, Middle, Maiden Surname): Effrona Puffinburger

19a. Informant's Name/Relationship (Type, Print): Al Largent (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 915 Hammonds Lane, Baltimore, Maryland 21225

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Mem Park
Date: 06-07-02
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: John L. Rampulla
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltuimore, Maryland 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart Failure	1yr
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Atrial Fibrillation	1yr.
Due to (or as a consequence of):		
c.	Atherosclerotic Cardiovascular Disease	10yrs
Due to (or as a consequence of):		
d.		

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Durt
29c. License number: D39660
29d. Date signed (Month, Day, Year): June 4 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Durt 901 E. Fort Ave. Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James L. Nelson
2. Dete of Deeth: Month JUNE Day 03 Year 2002
3. Time of Death: 1 30 AM.
4a. Fecility Neme (If not institution, give street end number): Levindale Hospital
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 212-32-7043
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. lest birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 27, 1937
9. Birthplece (State or Foreign Country): NC

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Baltimore County
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street end Number: 7808 Brevort Road
10f. Zip Code: 21244
10g. Citizen of What Country?: USA

11. Marital Stetus: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Postal Worker
16b. Kind of Business/Industry: U.S. Post Office

17. Fether's Neme (First, Middle, Last): John McQueen Nelson
18. Mother's Name (First, Middle, Maiden Surname): Clara Belton Nelson

19a. Informent's Neme/Retationship (Type, Print): Shirley Nelson, Wife
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 7808 Brevort Road, Baltimore, MD 21244

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park
Date: 6/7/02
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hart P. Close Funeral Service, P.A. 709 Tessier St., Baltimore, MD 21201-1925

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finat disease or condition resulting in death) e.	End stage Renal failure	7 years
Due to (or es a consequence of):		
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last b.	Coronary arterty disease	7 years
Due to (or es a consequence of):		
c.	Congestive Heart failure	7 years
Due to (or as a consequence of):		
d.		

Part II. **Other eignificent conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D44817
29d. Date signed (Month, Dey, Yeer): JUNE 04 2002

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Sunil P. Rejani 2434 W Belvedere ave, Baltimore

State Registrar

31. Dete filed (Month, Day, Yeer): JUN 06 2002
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18120

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELEASE NELSON
2. Date of Death: Month JUNE Day 01 Year 2002
3. Time of Death: 1:40 a.m.
4e. Facility Name (If not institution, give street end number): HARBOR HOSPITAH
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-24-2750
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-27-27
9. Birthplace (State or Foreign Country): S.Carolina

Usual Residence of Decedent

10a. Stete: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3724 Flowerton Rd.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: House

17. Father's Neme (First, Middle, Last): Peter Harvin
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Harvin

19a. Informant's Name/Relationship (Type, Print): Barbara Lewis Daughter
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 639 Charraway Rd, Baltimore, Md. 21229

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Mem. Pk.
Date: 6-5-04
20c. Location - City or Town, State: Randallstown, Md.

21. Signature of Funeral Service Licensee: Lloyd M. Estep
22. Name and Address of Facility: Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PNEUMONIA — 4 days
Due to (or as a consequence of): SEPSIS — 3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): DECUBITUS ULCER
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS; HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Victor Rostapshov MD, PhD
29c. License number: RES 000
29d. Date signed (Month, Day, Yeer): JUNE 01 2002

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): VICTOR ROSTAPSHOV 3001 SOUTH HANOVER STREET BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Day, Yeer): JUN 06 2002
32. Registrar's Signature: Brenda B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that tha daath certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5,8,16b,20a-c&22 PER FH C808. 6/11/02 JH **Certificate of Death** Reg. No. 2002 18121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clara Norman
2. Date of Death Month Day Year: May 29, 2002
3. Time of Death: 6:05 A M
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: ~~216~~ 214-72-8036
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb ~~19~~ 18, 1958
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 38 Walden Maple Court
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): security guard
16b. Kind of Business/Industry: ~~unk~~ SECURITY

17. Father's Name (First, Middle, Last): James Norman
18. Mother's Name (First, Middle, Maiden Surname): Clara Jackson

19a. Informant's Name/Relationship (Type, Print): Clarice Melvin/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 38 Walden Maple Court Baltimroe, MD 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) ~~in state~~
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY INC.
Date: 6-08-02
20c. Location - City or Town, State: BALTIMORE,MD.

21. Signature of Funeral Service Licensee: Joseph B. Van Sant
22. Name and Address of Facility: CREMATION OF MD. INC. ~~State Anatomy Board 333 W. Baltimore Street~~ Baltimore, MD ~~21201~~ 299 FREDERICK RD.LALTO.MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Brain Herniation Syndrome — Approximate Interval Between Onset and Death: 4 Hours
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Intracerebral Hemorrhage — 24 Hours
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], MD
29c. License number: P 14630
29d. Date signed (Month, Day, Year): May 30, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD AHN, MD 22 South Greene St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18122

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Joseph R Neuman	May 31, 2002	10:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Baltimore VAMC Extended Care	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216 20 5225	1 [X] M 2 [ ] F	74 Yrs.			Aug. 23, 1927	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Pasadena	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7747 Outing Avenue	21122	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Iron Worker	Iron Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Neuman	Agnes (not available)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edith Neuman / wife	7747 Outing Avenue Pasadena, Maryland 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	MD State Veteran Cem.	6/4/2002	Crownsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George D Gonce	Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's Disease	6 Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
David Lorello MD	D37070	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David Lorello M.D Baltimore VAMC Extended Care

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#1 perPHYG808 6/26/02 EW **Certificate of Death** Reg. No. 2002 18123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
~~JOHN~~ John Gilbert O'Brien ~~O'BRIEN~~	May 30 2002	1130 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BAYVIEW MEDICAL CENTER	BALTIMORE, MD	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-09-5852	1☒ M 2☐ F	82 Yrs.			Nov. 28, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Lutherville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
110 Othoridge Road	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Owner	Electrical Repair Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William C. O'Brien	Ada Bell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John G. O'Brien, Jr./Son	1608 Pinnter Rd., Lutherville, MD 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Loudon Park Cemetery	6/1/02	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Dayna M Reese

22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Ave., Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Peripheral Vascular Disease
Laryngeal Carcinoma

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No	26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐ Yes 2☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	RES-000	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATTIA JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4940 EASTERN AVE BALT, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Brenda B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 12+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18124

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Charles Maurice Phipps Jr	May 30, 2002	11:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carroll County General Hosptial	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-16-7748	1[X] M 2[ ] F	77 Yrs.			Mar 26, 1925	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Westminster	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
123 Washington Road	21157	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: WWII	1[ ] Yes 2[X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	unk	unk
8	0		

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Maurice Phipps, Sr	Elinor Brandt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Westminster Nursing Home	123 Washington Road Westminster, MD 21157

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[ ] Burial 2[ ] Cremation 3[ ] Removal from State 4[X] Donation 5[ ] Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Joseph B. Van Sant	State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[X] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[X] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D33184	May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jonathan Kushner 114 Business Center Drive Reisterstown, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Charles Maurice Phipps

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18125

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MORGANA LAVADA QUEEN
2. Date of Death Month 5 Day 26 Year 2002
3. Time of Death 2010 PM
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE City

Funeral Director

5. Social Security Number: none
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min. 42
8. Date of Birth (Month, Day, Year): May 26, 2002
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Landover
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2108 Columbia Avenue
10f. Zip Code: 20785
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Napoleon Queen
18. Mother's Name (First, Middle, Maiden Surname): Cathy Anderson

19a. Informant's Name/Relationship (Type, Print): UMMS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 S. Greene Street Baltimore, MD 21201

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service licensee: Joseph B. Van Sant
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. EXTREME PREMATURITY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
INFECTION / SEPSIS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): NA
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eric Reynolds MD
29c. License number: D0055756
29d. Date signed (Month, Day, Year): 5/26/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC REYNOLDS, MD U OF MARYLAND, DNISION OF NEONATOLOGY, 22 S. GREENE ST BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Patricia Ramey
CJ
02-2920-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar UNPENDED 061402:ITEMS#23a,27,28a-f per ME G808 ss **Certificate of Death** Reg. No. 2002 18126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Patricia	Ramey	June 03 2002	09:00 A. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
937 Armistead Way	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-66-5911	1☐ M 2☒ F	45 Yrs.			June 27,1956	Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
937 Armistead Way	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10 yrs.		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Darrell Willis	Laura Mullins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Laura Willis mother	937 Armistead Way, Baltimore,Md. 21205

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gardens Of Faith Cemetery	June 6, 2002	Rosedale,Md.

21. Signature of Funeral Service Licensee: Anthony C. Connelly

22. Name and Address of Facility: Connelly Funeral Home Of Dundalk,P.A. 7110 Sollers Point Road,Dundalk,Md. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. NARCOTIC INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☒ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Scene

27. Manner of Death 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
Found: 6-3-02	Found: 8:30a M	1☐ Yes 2☒ No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found in residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 837 Armistead Way, Baltimore, MD 21205

29a. Certifier (Check only one) 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. Kiyasu	O.C.M.E.	June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KIYASU 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002

32. Registrar's Signature: Bernice D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "nature", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Rawlings -McPhail

2. Date of Death: Month May Day 31 Year 2002

3. Time of Death: 1:00 A.M.

4a. Facility Name (If not institution, give street end number): Crofton Convalescent & Rehab. Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217 74 5402

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 45 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 24, 1956

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Severn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1649 Disney Road Apt. 2

10f. Zip Code: 21144

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Edcetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: McDonalds

17. Father's Name (First, Middle, Last): Tilghman Rawlings

18. Mother's Name (First, Middle, Maiden Surname): Mary Taylor

19a. Informant's Name/Relationship (Type, Print): James McPhail / Husband

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 1649 Disney Road Apt. 2 Severn, Maryland 21144

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Bayview Crematory, Inc.

Date: 6/4/02

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Shannon Leggett

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

parmit. Pages 1 and 2 should ba filed within 72 hours efter death with the Maryland Dapartmant of Haalth and Mantal Hygiene.

Important: If Item 27 is marked other than "neturel', or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Ovarian Carcinoma — 6 month

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: D Ch

29c. License number: D 38458

29d. Date signed (Month, Day, Yeer): 5/31/2002

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Daljeet Singh Sidhu 1413 Annapolis Road #106 odenton MD 21113

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002

32. Registrar's Signature: Joanne B Sparks

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificeta has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Margaret		Sumler	June 4 2002	3 22 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (If yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-28-1865	1 M 2 F	84 Yrs.			Sept. 16, 1917	South Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1200 Autumn Leaves Ct.	21202	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Brooks	Lula Brooks

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ms. Lula Casey (daughter)	218 Audrey Ave. Balto. Md. 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mt. Calvary Cem.	6/10/2002	Glen Burnie, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. urosepsis	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dehydration, anasarca, dry gangrene of right foot

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
C. DeRuiter	Res-000	June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cynthia DeRuiter The Johns Hopkins Hospital 600 N wolfe Street, Baltimore Maryland 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18129

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul Slepian
2. Dete of Deeth Month MAY Dey 31 Year 2002
3. Time of Death 7 33 AM
4a Feciity Neme *(If not institution, give street and number)*: Levindale Nursing Home
4b. City, Town, or Location of Death: Baltimore
4c. County of Deeth:

Funeral Director

5. Sociel Security Number: 026-16-4140
6. Sex 1☒ M 2☐ F
7. Age *(In yrs. lest birthday)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yeer)*: Mar 26, 1923
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usuel Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits 1☐ Yes 2☒ No
10e. Street end Number: 8909 Reisterstown Road
10f. Zip Code: 21208
10g. Citizen of What Country?: USA
11. Meritel Status 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:* X
14. Race - American Indien, Black, White, etc. *Specify:* white
15. Decedent's Edeetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 5
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: math professor
16b. Kind of Business/Industry: education
17. Fether's Neme *(First, Middle, Last)*: Philip Slepian
18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Goldstein
19a. Informent's Name/Relationship *(Type, Print)*: Laura Slepian/daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1101 St. Paul Street Baltimore, MD 21202
20a. Method of Disposition 1☐ Buriel 2☐ Cremation 3☐ Removal from State 4☒ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*:
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Joseph B. Van Sant — Joseph B. Van Sant
22. Name and Address of Feciility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)
a. End Stage Multiple Myeloma — 7 years
Due to (or es a consequence of):
b.
Due to (or es e consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia
Depression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Yeer)*:
28b. Time of Injury M:
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*:
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*:

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)* 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D44817
29d. Date signed *(Month, Day, Year)*: MAY - 31 - 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 2436 W Belvedere ave, Baltimore -

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 06 2002
32. Registrer's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Paul Slepian

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #24a per verbal G808 060602 SS

Certificate of Death

Reg. No. 2002 18130

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jean Teresa Rassier Spangler	June 5, 2002	7:45 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Casey House	Rockville	Montgomery

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-07-4250	1☐M 2☒F	85 Yrs.			Feb. 7, 1917	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Sandy Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1641 Hickory Knoll Road	20860	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Personnel Classifier	Dept. of Defense

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Julius Rassier	Katherine Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
George H. Spangler/Son	#22 Virginia Drive; Gaithersburg, MD 20877

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Loudon Park Crematory	06/07/2002	Baltimore, MD

21. Signature of Funeral Service Licensee: Arthur L. DiMarco

22. Name and Address of Facility: Simple Tribute Funeral & Cremation Center 1040 Rockville Pike; Rockville, MD 20852

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Gangrene of Right Lower Extremety — Months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	D35635	June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, MD 18111 Prince Philip Drive #327 Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy C. Shelton	June 2, 2002	12:55 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Villa Nursing Home	Catonsville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
240-30-9990	1☐M 2☒F	77 Yrs.			Oct. 26, 1924	North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Catonsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
46 Delrey Ave.	21228	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Administration	Social Security Admin.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Theodore Shelton	Georgia Kimmons

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Georgette Sasscer (Sister)	46 Delrey Ave., Catonsville, MD 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Loudon Park Cemetery	6/5/02	Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Loudon Park Funeral Home
3620 Wilkens Ave., Baltimore, MD 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimer's Disease

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Raymond Miller MD	D0768 3	6/5/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Raymond Miller 25 Main Street Suite 200 Reisterstown MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 3

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item 24a Ver.,G808,06/06/02dhb

Certificate of Death

Reg. No. 2002 18132

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Senazha Shariff-Bonaparte

2. Dete of Deeth: Month MAY Dey 26 Year 2002

3. Time of Death: 0523

4e Fecility Neme (If not institution, give street end number): SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Deeth:

Funeral Director

5. Social Security Number: 086-42-1190

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): 09 02 48

9. Birthplace (State or Foreign Country): NY

Usuel Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 9 Rambling Oaks Way Apt I

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12th grade

College (1-4or 5+): 2 yrs

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shop Steward

16b. Kind of Business/Industry: Gas & Electric Co.

17. Father's Neme (First, Middle, Last): Charles McGhee Sr.

18. Mother's Name (First, Middle, Maiden Surname): Lucille Shirley

19a. Informant's Name/Relationship (Type, Print): Sakinah Shariff-Daughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1838-3 Patton Drive, Ft. Meade Md 20755

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc. Date: 6/3/02

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Glynis B. Keke

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

To Be Completed by Funeral Director

BONAPARTE, SENAZHA

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)

a. MULTI SYSTEM ORGAN FAILURE — 48 HRS

Due to (or es a consequence of):

b. REDO AORTAL + MITRAL VALVE REPLACEMENT — 17 DAYS

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c. ENDOCARDITIS — 2 MONTHS

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: Peter W. Cho (MD)

29c. License number: D41129

29d. Date signed (Month, Dey, Year): MAY 26 2002

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): PETER CHO M.D. 2411 W BELVEDERE AVE BALTIMORE MD 21215

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrer's Signature: Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18133

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
RUTH	MARGOLIES	SELKO	JUNE 3, 2002	9:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MONTGOMERY GENERAL HOSPITAL	OLNEY	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
181-30-8292	1☐M 2☒F	93 Yrs.			SEP. 1, 1908	N.Y.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	OWINGS MILLS	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6 LIBERTY RIDGE COURT	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		TEACHER	EDUCATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SIMON WEINGARTEN	LENA (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOEL MARGOLIES / SON	6 LIBERTY RIDGE COURT - OWINGS MILLS, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BETH DAVID CEMETERY	6/5/2002	ELMONT, NEW YORK

21. Signature of Funeral Service Licensee: Registered

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE CONGESTIVE HEART FAILURE	15 MINUTES
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HYPERTENSION	YEARS
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ASTHMA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☑No

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Emily Jackman	D25947	JUNE 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3446 OLANDWOOD COURT SUITE 200 OLNEY, MARYLAND 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	Angela D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18134

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
RUTH		SILVERMAN	JUNE 4, 2002	12:55 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JEWISH CONVALESCENT HOME	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
216-20-2733	1☐ M 2☒ F	75 Yrs.			JULY 14,1926	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7920 SCOTTS LEVEL ROAD	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* WHITE

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		SALESPERSON	RETAIL WOMEN'S APPAREL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM BASCH	JENNIE LEVY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
MARILYN WEINER / SISTER IN LAW	7304 MARRIOTTSVILLE ROAD - MARRIOTTSVILLE, MD 21104

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	(ANSHE EMUNAH) AITZ CHAIM	6/5/02	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward C. Rund	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. AMYOTROPHIC Lateral Sclerosis	1 YEAR
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to tha causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D15140	JUNE 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IAN SUNSHINE MD 6210 PK Hts Ave, BALT, MD 21215

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
JUN 0 6 2002	▶ Bernice B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18135

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): WALTER STAUDE

2. Date of Deeth: Month MAY Day 30 Year 2002

3. Time of Death: 4:21 PM

4a. Facility Neme (If not institution, give street end number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 369 28 0408

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): June 16, 1928

9. Birthplace (State or Foreign Country): Michigan

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1825 Cremen Road

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipe Inspector

16b. Kind of Business/Industry: Anne Arundel County

17. Father's Neme (First, Middle, Last): (not available) Staude

18. Mother's Name (First, Middle, Maiden Surname): (not available)

19a. Informant's Name/Relationship (Type, Print): Janet Staude / wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 1825 Cremen Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.

Date: 6/3/02

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Znamierowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. HEMORRHAGIC SHOCK — 1 DAY

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC BOWEL — 4 DAYS

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ESOPHAGEAL CANCER; STATUS POST ESOPHAGECTOMY

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: M Farah M.D.

29c. License number: D 0058292

29d. Date signed (Month, Dey, Year): MAY, 30, 2002

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): MARINA FARAH, M.D. 3001 SOUTH HANOVER STREET, BALTIMORE, MD 21225

State Registrar

31. Dete filed (Month, Day, Yeer): JUN 06 2002

32. Registrer's Signeture: Barbara B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18136

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Melvin H. Thompson
2. Date of Death: Month May Day 31 Year 2002
3. Time of Death: 5:15P M
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-20-3185
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 18, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 1705 N. Ashburton St.
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Private Firm

17. Father's Name (First, Middle, Last): Clarence Bradford
18. Mother's Name (First, Middle, Maiden Surname): Emma Hansen

19a. Informant's Name/Relationship (Type, Print): Mr. Ronald Hantz (nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1429 Girard St. N.W. Washington, D.C. 20009

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest
Date: 6/11/2002
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrythmia. — 45 mts.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Aspiration Pneumonia — 40 mts
c. Due to (or as a consequence of): G.I. Bleed upper — 30 mts.
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tariq Khan.
29c. License number: D 0021730
29d. Date signed (Month, Day, Year): June 5 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tariq Khan, Sinai Hospital of Baltimore, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature: Geneva G. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Thompson, Melvin

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #18 PER FH G808 6/06/02 ## **Certificate of Death**

Reg. No. 2002 18137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Claude W. Tunstall	June 3 2002	8:54 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Northwest Hospital	Randallstown	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-20-0577	1☑M 2☐F	71 Yrs.			May 30, 1931	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Lochearn	1☐Yes 2☑No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6725 Brompton Rd.	21207	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☑Never Married 2☐Married 3☐Widowed 4☐Divorced	1☑Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Handyman	Home Improvement

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Tunstall	Viola ~~Tunstall~~ TUNSTALL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth Crowder - caregiver	3002 Essex Rd. Lochearn, MD 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☑Other (Specify)	Garrison Forest V.A.	6-10-02	Owings Mills, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Gary P. March Funeral Home P.A. 2470 Fredhilton Pass Balto., MD 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic lung cancer	>1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease
Chronic autocatabolic state
Anemia

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J Boston M.D	D28462	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Boston Northwest Hospital Center Randallstown Maryland 21133

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Rickey Sterling Tate	JUNE 02 2002	7:55 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VAMC, FORT HOWARD, MD 21052	FORT HOWARD	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
245-84-9376	1☐M 2☐F	50 Yrs.			5-3-1952	NORTH CAROLINA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore	XX Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1617 Balmar Ct.	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4 X Divorced	1 X Yes 2☐No If Yes, Give Year or Dates: 74-78	1☐Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Cabinet Maker	Cabinet Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Tate	Mary Tate

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Howie Sister	3605 Edmondson Ave, Baltimore, Md. 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Tate Cemetery	6-8-02	Elizabeth, N.C.

21. Signature of Funeral Service Licensee: Lloyd M Estep

22. Name and Address of Facility: Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CIRRHOSIS OF LIVER	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. HEP. C	
	Due to (or as a consequence of):	
	c. ALCOHOL	
	Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2 X No	1☐Yes 2 X No

25. Was case referred to medical examiner? 1☐Yes 2 X No

26. Place of Death (Check only one): Hospital: X 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D57239	JUNE 02, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH SHANDELYA, MD 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	

DHMH 17 Rev 1/2001

ORIGINAL

TATE, RICKEY S. # 9376
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Clara Faye Wilkinson	June 04, 2002	3:15 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Ivy Hall	Middle River	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-34-1246	1 ☐ M 2 ☒ F	92 Yrs.			July 7, 1909	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Middle River	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
801 Compass Road	21220	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clarence Gilmore	Leta Katterman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Brenda Knee (Daughter)	801 Compass Road, Baltimore, Maryland 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Meadowridge Mem. Pk.	June 7, 2002	Elkridge, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hyperten Fin

Due to (or as a consequence of):

c. Carcinoma of Cervix

Due to (or as a consequence of):

d. Dementi

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dvesturlisis

Trygeminal Neuralgia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D 31464	6/5/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOAIB A. HASHMI, 821 N. Eutaw St Suite 308, Balt. MD 2124

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	Linda L. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Clara Wilkinson 6/4/02 3:15pm

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18140

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Andrew Henry Wilfer
2. Date of Deeth Month: June Dey: 4 Year: 2002
3. Time of Death: 8:25 pm
4e Facility Neme (If not institution, give street end number): 1501 Cherry Garden Road
4b. City, Town, or Location of Deeth: Essex
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 220-12-5157
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. lest birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): May 6, 1926
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street end Number: 1501 Cherry Garden Road
10f. Zip Code: 21221
10g. Citizen of What Country?: U. S. A.

11. Maritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1944 1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 10 | College (1-4or 5+):
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Steel Mill

17. Father's Neme (First, Middle, Lest): Henry Joseph Wilfer
18. Mother's Name (First, Middle, Maiden Surname): Katherine Hock

19a. Informant's Name/Relationship (Type, Print): Dolores Cecelia Wilfer (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1501 Cherry Garden Road Essex, Maryland 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem.
Date: 6/7 2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael C. Zaffuto M00938
22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Cardiac Arrest

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last:
Due to (or es a consequence of): b. Respiratory Arrest
Due to (or es e consequence of): c. CAD
Due to (or es e consequence of): d. HTN

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner as stated. 2 ☐ **Medicat Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: Helen Simpson MD
29c. License number: 041678
29d. Date signed (Month, Dey, Year): 6/5/02

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Helen Simpson, MD 1245 Eastern Blvd Baltimore, MD 21221

State Registrar

31. Date filed (Month, Day, Year): JUN 0 6 2002
32. Registrar Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death cartificate be executed within 24 hours after death.
To the Funerel Director: After this cartificata has been signed by the attending physician end completely fillad in by the funerel director, page 2 should be datached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18141

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gertrude Williams
2. Date of Death: Month June Day 1 Year 2002
3. Time of Death: 12:25 PM
4a. Facility Name (If not institution, give street and number): Lorien Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 220-18-3406
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 3, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6334 Cedar Lane
10f. Zip Code: 21222
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician
16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Melvin Smith
18. Mother's Name (First, Middle, Maiden Surname): Gertrude Toomey

19a. Informant's Name/Relationship (Type, Print): Rosalyn Williams
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3532 Frederick Ave. Balto., MD 21229

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Mem. Pk.
Date: 6-5-02
20c. Location - City or Town, State: Arbutus, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Gary P. March F/H P.A. 270 Fredhilton Pass Balto. MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. GI Bleeding — Approximate Interval Between Onset and Death: months
Due to (or as a consequence of):
b. Colon Cancer — months
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus, Cerebrovascular accident
Hypertension, Dementia, Anemia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: physician
29c. License number: D-52544
29d. Date signed (Month, Day, Year): June 4, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Benjamin S. Lee, M.D. 700 Gerpe Rd #204, Catonsville MD 21228

State Registrar

31. Date filed (Month, Day, Year): JUN 06 2002
32. Registrar's Signature:

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18142

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Arrie		Wells	May 30, 2002	7:50 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Hospital	Baltimore	B-14

Funeral Director

5. Social Security Number	6. Sex	7. Age (If yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216 10 1440	1 X M 2 ☐ F	90 Yrs.			12 10 11	FLORIDA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	n/a	BALTIMORE	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
528 S. PACA	21230	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates: X	1 ☐ Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	CUSTODIAN	B.G.&E

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GENERAL WELLS	DAISY WELLS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BOBBY WELLS	6429 CRAIGMONT RD. BALTO. MD. 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CEDAR HILL	6/4/02	BROOKLYN, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ C.A.ESTEP C.A. Estep	ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PL. BALTO, MD 21217

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 X No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ R. Schneider, MD	P15905	May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard Schneider, MD 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 06 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #8 PER FH G808/6/13/02 JH

Certificate of Death

Reg. No. 2002 18143

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
IAN	MITCHELL	WAGNER	MAY 30, 2002	4:55 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6409 LEWIS ROAD	BALDWIN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-50-5269	1 X M 2 F	53 Yrs.			AUG 20 1948	N.Y.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	WORCESTER	OCEAN CITY	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
259 SOUTH OCEAN DRIVE	21842	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		HEALTH & SAFETY OFFICER	U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LOUIS NAST WAGNER	ESTHER FRIMET

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MS. LAUREN S. WAGNER/ DAUGHTER	337 W. 43RD STREET APT. 2-B NEW YORK CITY,NY.10036

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ARLINGTON NATIONAL	6/19/2002	FT. MYERS, VA.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS
OBESITY

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably 4 X Unknown	1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) FRIEND'S RESIDENCE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] Charles F. O'Donnell MD	MD-09383	MAY 31,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CHARLES F. O'DONNELL MD. 111 HAMLET HILL ROAD BALTIMORE,MD. 21210

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 0 6 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruby K. Williams
2. Dete of Death: Month: May; Dey: 29; Year: 2002
3. Time of Death: 6:20 A.M.

4a Facility Name (If not institution, give street end number): Gladys Spellman Specialty Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 214 38 1129
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months; Deys
If Under 24 Hrs.: Hours; Min.
8. Date of Birth (Month, Day, Year): Aug. 31, 1927
9. Birthplace (State or Foreign Country): Tennessee

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 222 Cresswell Road
10f. Zip Code: 21225
10g. Citizen of Whet Country?: U.S.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specily:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Eduction (Specify only highest grede completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Restaurant

17. Father's Neme (First, Middle, Last): Jerome Joans
18. Mother's Name (First, Middle, Maiden Surname): Mary Lamon

19a. Informant's Name/Relationship (Type, Print): Reba Kratochuil / Daughter
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 222 Cresswell Road Baltimore, Maryland 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Prince Frederick Meth. Church Cemetery
Date: 6/1/02
20c. Location - City or Town, State: Prince Frederick, MD

21. Signature of Funeral Service Licensee: Jerome Joans
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finat disease or condition resulting in death)	a. SEPSIS	2 weeks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure Ventilator Dependence

Chronic Obstructive Lung Disease

Congestive Heart Failure

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ptace, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Paul A. Devure MD
29c. License number: D01852
29d. Date signed (Month, Day, Year): May 29, 2002

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): Paul A. Devure MD 4203 Queensbury Road Hyattsville, Maryland 20791

State Registrar

31. Dete filed (Month, Day, Year): JUN 0 6 2002
32. Registrer's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificate be axecuted within 24 hours after death.
To the Funeral Director: Attar this certificate has been signed by the attending physician and completely filled in by tha funeral director, pege 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Lloyd Ray Anderson	5	22	2002	8:10 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Regency Nursing Center	Forestville	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
237-72-4513	1☒M 2☐F	54 Yrs.					08-23-1947	Greenville, NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DC		Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
930 M. St NW	20001	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Certified Chef	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Isaiah Anderson	Gracie Patrick

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Moore/Sister	6204 Roanoke Ave Riverdale, MD 20737

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Greenwood Cemetery	05-28-2002	Greenville, NC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Janeka Yates	JB Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Fulminent Hepatic Failure	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hepatic Encephalopathy	
	Due to (or as a consequence of):	
	c. Alcohol Abuse	
	Due to (or as a consequence of):	
	d. Human Immunodeficiency Virus	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Malnutrition

Coagulopathy

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Vionalson V. Monilkam MD	D57675	5-23-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Vionalson V. Monilkam, MD 7420 Marlboro Pike Forestville, MD 20767

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 2 4 2002	Sandra B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (6)

DHMH 17 Rev 1/2001

ORIGINAL

Reginald L. Anderson
02-2564-033
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Reginald L. Anderson
2. Date of Death: Month May Day 17 Year 2002
3. Time of Death: 10:27 AM
4a. Facility Name (If not institution, give street and number): Fort Washington Hospital
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 341448848
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 22, 1950
9. Birthplace (State or Foreign Country): IL

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2256 Ravenna Court
10f. Zip Code: 20603
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 3/19/71 - 10/29/72
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Manager
16b. Kind of Business/Industry: US Gov't

17. Father's Name (First, Middle, Last): William Anderson
18. Mother's Name (First, Middle, Maiden Surname): Christine Meredith

19a. Informant's Name/Relationship (Type, Print): Gloria Anderson Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2256 Ravenna Court Waldorf, MD 20603

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cheltenham Veterans Cemetery
Date: May 24, 2002
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ Nelson E. Greene
22. Name and Address of Facility: Greene Funeral Home Inc 814 Franklin St. Alexandria, VA 22314

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC ARRYTHMIA
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. CARDIOMEGALY
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Marjorie Bellfield MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): May 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYPONDA D. KOROL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002
32. Registrar's Signature: Geneva D. Sparks

CR (25)

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18147

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
KATHERINE E. ALVEY	MAY 19 2002	1:48p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHERN MARYLAND HOSPITAL	CLINTON	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579 20 5369	1☐M 2☒F	89 Yrs.			April 17, 1913	Washington D.C

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Clinton	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7520 Surratts Road	20735	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Sales Representative	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward H. Stowe	Olive Herbert

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty Neill/daughter	2808 Ritchie Road Forestville, MD 20747

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Hill Cemetery	May 23	Suitland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kimberly C Busca-Tonic	Marshall's Funeral Home of MD 4308 Suitland Road Suitland, MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest

Due to (or as a consequence of):
b. Atherosclerotic cardiovascular dis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Age

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Glucose Intolerance, Peripheral Vascular Disease, Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Rene Grace, MD	D02257	May 19 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rene Grace MD 9131 Piscataway Rd Clinton, MD 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Mary Kathleen requested 5-19-02 @ 1348

CR (6)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18148

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)				2. Date of Death Month Day Year	3. Time of Death
HARRIETT	RETA	BOZMAN	ADKINS	May 16 2002	11:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Wicomico Nursing Home	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer)	9. Birthplace (State or Foreign Country)
214-10-6393	1☐M 2☒F	85 Yrs.			July 2,1916	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
31390 Mt. Hermon Road	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	-	Housewife	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Edward Bozman	Nancy Catherine Bozman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bonnie K. Adkins/Daughter	6838 Edwards Ave., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parsons Cemetery	5/20/02	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kelli K Dorney CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

TYPE 2 DIABETES

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MOHAN BHAT	D55006	MAY 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mohan Bhat MD 614 Easternshore Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

Certificate of Death

Reg. No. 2002 18149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
LLewellyn	Berry	May 14, 2002	11:10P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montegomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
174-60-0999	1☐M 2☒F	31 Yrs.			Feb.7,1971	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	PG	Hyattsville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7015 Highview Terrace		USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Black Specify:

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	1½ Years	Manager	Restuarant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LLewellyn Berry Sr.	Patricia Clyburn

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mother) Patricia Berry Jackson	3703 Chesholm Rd.,Baltimore,Md.21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Northern Va.Crem.	5/18/02	Arlington,Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Charles Samuels III	Tri-State F/S/Inc 912 Third St.NW,Wash.D.C.20001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Cryptococcal Meningitis	7 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of): Acquirred Immunodeficency Syndrone	3 Years
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Divya Verma MD	D 52298	May 15, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr.Divya Verma,7525 Greenway Center Dr.,Greenbelt,Md. 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Sandra B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (2)

DHMH 17 Rev 1/2001

ORIGINAL

02-2573-003
B.K.S
GABRIELE R. BORNMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar UNPENDED 060702:ITEMS#23a,27,28a-f per ME 6808 ss

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gabriele Rose Bornman	MAY 18, 2002	0751 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-54-5893	1☐ M 2☒ F	44 Yrs.			May 22,1957	Germany

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel	Crofton	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2060 Aberdeen Drive	21114	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	In home nursing	Medical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gabriel George Delmonico	Marieluise Delmonico

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jason George Dennis son	2060 Aberdeen Dr., Crofton, Md. 21114

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	05-24-02	Alexandria, VA.

21. Signature of Funeral Service licensee ▶ [signature]

22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ALCOHOL AND DOXEPIN INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined	Found: 5-18-02	Found: 6:30a M	1☐ Yes 2☒ No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Unknown	14 Largo Rd., Millersville, MD

29a. Certifier (Check only one) 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E	MAY 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

CR

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pauline Brooks

2. Date of Death: Month May Day 18, Year 2002

3. Time of Death: 5:20 AM

4a. Facility Name (If not institution, give street and number): Forest Glen Skilled Nursing Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 283-26-3771

6. Sex: 1☐ M X☐ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): 10-22-1929

9. Birthplece (State or Foreign Country): Ohio

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: XX☒ Yes 2☐ No

10e. Street end Number: 2700 Barker Street

10f. Zip Code: 20910

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Towel Supply Co.

17. Fether's Neme (First, Middle, Last): Willie Green

18. Mother's Name (First, Middle, Maiden Surname): Eunice Williams

19a. Informent's Name/Relationship (Type, Print): Corensa Brooks (Son)

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 3421 University Blvd. #303 Kensington, MD 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Belmont Park

Date: 5/28/02

20c. Location - City or Town, State: Youngstown, Ohio

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Austin Royster Funeral Home 3821 14TH ST N.W. Washington, DC 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in deeth): e. Acute Myocardial Infarction — Sudden

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic heart disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D06674

29d. Date signed (Month, Day, Year): 5/20/02

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MYRON L. LEWKIN MD 2364 SHERIDAN FIELD RD WHEATON MD 20902

State Registrar

31. Date filed (Month, Dey, Year): MAY 2 4 2002

32. Registrer's Signature: [signature]

CR 5

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18152

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
EDWARD HENRY BOONE JR	MAY 15 2002	10:22 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NATIONAL NAVAL MEDICAL CENTER	BETHESDA	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
224-52-2670	1 [X] M 2 [ ] F	68 Yrs.			12-23-1933	VA Norfolk County,

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Temple Hills	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3412 Brinkley Rd #102	20748	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Engineer	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Henry Boone Sr	Angelina Scott

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Faiza Boone/Wife	3412 Brinkley Rd #102 Temple Hills, MD 20748

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Arlington National	06-11-2002	Arlington, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	JB Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PULMONARY HYPERTENSION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	46706 (IN)	05 16 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
KENNETH ORTIZ, LCDR, USN	NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD, 20889-5600

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

R (6)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18153

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Earl	Bumbray	May 12, 2002	6:55 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Mariner Health Care	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
231-12-3665	1[X] M 2[ ] F	92 Yrs.			June 20, 1909	Bristersburg, VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1131 University Blvd. West 1609	20902	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 years		Construction Worker	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Green	Mamie Bumbray

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sharon Watts - Grand-daughter	11204 Cherry Hill Rd. #202 Beltsville, MD 20705

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Resurrection Cemetery	May 20, 2002	Clinton, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd., NE Washington, DC 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular Accident	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Generalized Arteriosclerosis

Peripheral Vascular Disease

Severe Dementia

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[X] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D09834	May 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Barry N. Rosenbaum 3720 Farragut Ave. NW Kensington, MD 20895

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

CR (2)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
SAMUEL U. BROWN	May 16, 2002	5:42 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY COUNTY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577 48 3149	1☒M 2☐F	65 Yrs.			Dec. 25, 1936	Washington Dc

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Brentwood	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3703 Taylor Street	20722	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Bus Driver	P. G. County Schools

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Marshall Brown	Alice Simms

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mathenia M. Brown/ wife	3703 Taylor Street Brentwood, MD 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Washington National	May 23	Suitland, MD

21. Signature of Funeral Service Licensee: Kimberly Briscoe-Tonic

22. Name and Address of Facility: Marshall's funeral Home of MD 4308 Suitland Road Suitland, MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. BOWEL ISCHEMIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Gout, Alcoholism, Esophageal Varices

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Lynne Diggs, M.D.	D34472	May 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Lynne Diggs, M.D. 1500 Forest Glen Rd Silver Spring, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Barbara B. Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18155

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Geraldine Birch	May 20 2002	1:10 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-32-0996	1 ☐ M 2 ☒ F	75 Yrs.			Feb. 07 1927	Washington D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Crofton	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1535 Crofton Parkway	21114	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Baldwin	Annie Maude Hoffman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gary R. Birch Son	1120 Charing Cross Drive Crofton,MD 21114

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	MD Veterans Cemetery	May 22 2002	Crownsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert E. Evans	Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie, Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lymphoma	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	HS3041	5-20-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael Stanfire, DO 2202 Medical Parkway Ste 6th flr Annapolis, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18156

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
William	R.	Brown	May 21, 2002	6:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3103 Lumar Drive	Fort Washington	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
317-34-7059	1☒M 2☐F	66 Yrs.			11/23/1935	Kentucky

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Fort Washington	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3103 Lumar Drive	20744	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 9/1954 to 9/1974	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Military	U.S. Air Force

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Edward Brown	Margaret Mary Drury

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathleen M. Brown / Wife	3103 Lumar Drive Ft. Washington, Maryland 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Trinity Mem'l. Gardens	05/25/2002	Waldorf, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
George P. Kalas	George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GLIOBLASTOMA MULTIFORME	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnent at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☒Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D53885	5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
VENKAT S. [illegible] 7501 SUITLAND ROAD #307 CLINTON MD 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

DHMH 17 Rev 1/2001

ORIGINAL

Amended #1, nls,
05/20/02, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Cathrine~~ Catherine Mary Braunlich
2. Date of Death (Month, Day, Year): 05/16/2002
3. Time of Death: 2020
4a. Facility Name (If not institution, give street and number): Devlin Manor Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 335-14-0121
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06/12/1913
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 235 Paca Street
10f. Zip Code: 21502
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): George Maffley
18. Mother's Name (First, Middle, Maiden Surname): Agnes (Simpson) Maffley

19a. Informant's Name/Relationship (Type, Print): Sam Spair/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1267 Dunamon Dr., Bartlett, IL 60103

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): The Cumberland Crematory
Date: 5/17/02
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Robert C. Adams
22. Name and Address of Facility: Merritt-Adams Funeral Home, PA 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy — 3 mo
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Ischemic coronary artery disease — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D0017565
29d. Date signed (Month, Day, Year): May 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A J Billino 922 North Hwy Cuba MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002
32. Registrar's Signature: ▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

3/3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18158

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anne Marie Barna
2. Date of Death Month Day Year: MAY 16, 2002
3. Time of Death: 20:35 M
4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-20-6890
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 15, 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: LaVale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 77 Eleanor St.
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own home

17. Father's Name *(First, Middle, Last)*: Walter Sturtz
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Porter

19a. Informant's Name/Relationship *(Type, Print)*: Cindy Deneen /daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 77 Eleanor St., LaVale, MD 21502

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* Entombment
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Restlawn Maus.
Date: May 20, 02
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Robert C. Ackerman
22. Name and Address of Facility: Harvey H. Zeigler FH, Hyndman, PA 15545

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 24 HOURS

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC BRONCHITIS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. EMPHYSEMA WITH EXACERBATION
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mark A. Sagin
29c. License number: D35481
29d. Date signed *(Month, Day, Year)*: MAY 17, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAGIN, MARK A., M.D., 600 MEMORIAL AVENUE, SUITE 400, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

ANNE MARIE BARNA 215-20-6890

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 | 8159

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EFFIE MAE BUNNER	MAY 17, 2002	2:55 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. VINCENT dePAUL NURSING CENTER	FROSTBURG	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-24-0271	1 ☐ M 2 ☒ F	82 Yrs.			Aug 9, 1919	WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Frostburg	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
48 Tarn Terrace	21532	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Seamstress	Burton's Clothing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jesse Whetzel	Mary unk

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judy Logsdon daughter	11006 Dakota Avenue NW;LaVale MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Pleasant Grove Cemeter	5/21/2002	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVASCULAR ACCIDENT	ONE MONTH
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robustiano J. Barrera	D-14865	MAY 18TH, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robustiano J. Barrera, M.D.; Memorial Hospital Medical Bldg; Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	▶ G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

MD

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18160

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DANIEL WEBSTER BARNES	May 18 2002	3:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-66-9048	1 X M 2 ☐ F	47 Yrs.			DEC. 24, 1954	WEST VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	MINERAL	SPRINGFIELD	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
HC 86, BOX 30	26763	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: '73-'76	1 ☐ Yes X ☐ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		ENGINEER	ALLEGANY BALLISTICS LABORATORY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
EDGAR V. BARNES	VIRGIE MAE KEPLINGER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DAVID W. BARNES / SON	P.O. BOX 2222 - SITKA, AK 99835

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	FORT ASHBY CEMETERY	05/22/2002	FORT ASHBY, WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Henry R. Upchurch	UPCHURCH FUNERAL HOME, INC. P.O. BOX 1260 - FORT ASHBY, WV 26719

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	INFARCTION	UNKNOWN
Due to (or as a consequence of): b.	ALCHOL LIVER DISEASE / CIRRHOSIS	UNKNOWN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

HYPOTENSION

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 X No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert Wetter	D31573	May 8 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Wetter M.D. 902 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	▶ G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Needed to M.E.

11

yes

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18161

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*	2. Date of Death Month Day Year	3. Time of Death
LEVENIA AGNES BROWN	May 18, 2002	1315

4a. Facility Name *(If not institution, give street and number)*	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington County

Funeral Director

5. Social Security Number	6. Sex	7. Age *(In yrs. last birthday)*	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth *(Month, Day, Year)*	9. Birthplace *(State or Foreign Country)*
220-18-0779	1☐ M 2☒ F	76 Yrs.			Sept. 13,1925	Maryland

Usual Raisdance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Washington Co.	Hagerstown	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
55 East Washington Street	21740	U.S.A.

11. Marital Status	12. Was Dacedant Ever in U.S. Armad Forcas?	13. Was Dacedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.)	14. Race - Amarican Indian, Black, Whita, atc.
1☐ Navar Marriad 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education *(Specify only highest grada complatad)*		16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
8	0	Cook	Restaurant

17. Fathar's Name *(First, Middla, Last)*	18. Mother's Name *(First, Middla, Maiden Surnama)*
George Pilgrim	Goldie Hutzell

19a. Informant's Name/Relationship *(Type, Print)*	19b. Mailing Addrass *(Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)*
Robert E. Startzman/Son	1222 W. Washington St., Hagerstown, MD 21740

20a. Method of Disposition	20b. Place of Disposition *(Name of cemetery, crematory or other place)*	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*	Price's Cemetery	May 22	Waynesboro, PA

21. Signatura of Funaral Sarvica Licensee	22. Nama and Addrass of Facility
▶ Douglas A. Fiery	Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

22a. Part1. Entar th disaas, or complications that causad tha death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one ceuse on aach line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Cardiopulmonary arrest

Due to (or as a consaquence of):

Sequentially list conditions, if any, leading to immadiate ceusa. Enter Underlying Causa (Disaase or injury that initiated evants rasulting in daath) Last

b. Pneumonia

Due to (or as a consequence of):

c. End stage renal failure

Due to (or as a consequence of):

d. Atrial fibrillation

Part II. **Othar significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

23b. **Did tobacco use contributa to tha causa of death?** 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy parformed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28a. Place of Injury - At home, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Streat and Numbar or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*

1☐ **Certifying Physician**: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2☒ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signatura and titla of cartifiar	29c. Licansa number	29d. Date signad *(Month, Day, Yaar)*
▶ mD	D X 60531 1	May 18, 2002

30. Nama and addrass of person who complatad causa of daath (Item 23a) (Typa, Print)

Dr. Yu 12931 Oak Hill Avenue, Hagerstown, Maryland 21742

State Registrar

31. Data filad *(Month, Day, Yaar)*	32. Ragistrar's Signature
MAY 23 2002	▶ Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mantal Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law raquires that tha death cartificate be executed within 24 hours after daath.

To the Funeral Director: After this certificate has been signed by the attanding physician and completaly filled in by tha funeral director, paga 2 should be datached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18162

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Charles John Brown Jr
2. Date of Death Month: May Day: 23 Year: 02
3. Time of Death: 730A
4e. Facility Neme (If not institution, give street end number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-68-1160
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 39 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Oct. 8, 1962
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 833 Lanvale Street
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Business/Industry: none

17. Father's Neme (First, Middle, Last): Charles John Brown Sr.
18. Mother's Name (First, Middle, Maiden Surname): Blanche Dolores Staubs

19a. Informant's Name/Relationship (Type, Print): Charles J. Brown Sr. - brother
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 918 Rose Hill Ave., Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Leitersburg Cemetery
Date: 5/18/02
20c. Location - City or Town, State: Leitersburg, Maryland

21. Signature of Funeral Service Licensee: Scott M Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary occlusion — sudden

Due to (or as a consequence of):
b. Atherosclerotic disease — yrs

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
diabetes

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2☒ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: H. N. Weeks MD
29c. License number: D0011264
29d. Date signed (Month, Dey, Year): MAY 23, 02

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): H.N. Weeks MD 580 Northern Av Hagerstown, Md

State Registrar

31. Dete filed (Month, Day, Year): MAY 24 2002
32. Registrer's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18163

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Walter Edward Brown	MAY 26 2002	0838 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-28-3832	1 [X] M 2 [ ] F	69 Yrs.			July 15, 1932	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Frederick	Sabillasville	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4510 Foxville Rd.	21780	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5	Processor	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clyde A. Brown	Susie D. Willard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Smith (Sister)	25320 Springdale Ave. Cascade, Md. 21719

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Mt. Bethel Cemetery	May 29, 2002	Foxville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dennis R Travis	Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 6 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Coronary Artery Disease — 20 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No	26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 [ ] Yes 2 [ ] No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert Brull MD Personal Physician	D04359	May 27, 2002

30. Name and address of person who completed cause of death (Item 28a) (Type: Print)

Robert Brull 1459 Potomac St. Hagerstown, Md 21742

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Brown, Walter Edward

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Jean Bussard
2. Date of Death Month: 05 Dey: 26 Year: 02
3. Time of Death: 10:15 pm
4a. Facility Name (If not institution, give street and number): Beverly Health Care Center
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 074-18-9005
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 21, 1922
9. Birthplace (State or Foreign Country): Pennsylvani

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street end Number: 10910 Bayberry Court
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)
Elementery/Secondary (0-12): 11
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Neme (First, Middle, Last): John - Urban
18. Mother's Name (First, Middle, Maiden Surname): Anna - Verostek

19a. Informant's Name/Relationship (Type, Print): Anna B. Swart / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10910 Bayberry Court, Hagerstown, MD 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Rest Haven Cemetery
Date: 06/01/02
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Joseph P. Swart
22. Name and Address of Facility: Rest Haven Funeral Chapel, 1601 Pennsylvania Ave. Hagerstown, MD 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Carcinoma — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Mayan g May
29c. License number: D28365
29d. Date signed (Month, Day, Yeer): 5-28-02.

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): MANZAR. ISHAK 368 Mill Street Hagerstown MD 21740

State Registrar

31. Dete filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Barbara G. Spruth

Baltimore, Maryland 21215-0036

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
OTHO	PRESTON	BURKE	MAY 19 2002	3:35P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7865 BENNETT PARK DRIVE	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-32-8206	1 [X] M 2 [ ] F	66 Yrs.			02/ 20/1936	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7865 BENNETT PARK DRIVE	21801	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5		MAINTENANCE	POULTRY INDUSTRY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FREEMAN BURKE, SR.	BERTHA DRYDEN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PATRICIA TAYLOR - NIECE	7865 BENNETT PARK DR. SALISBURY MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	SPRINGHILL MEM. GARD.	5/23/2002	HEBRON, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
B. Keith Phippin, CFSP	BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. 21804 SALISBURY, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gastric cancer.	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Kimberly A. Richardson MD	D57978	05-20-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kimberly Richardson, MD. 428 W. Market St. SNOW Hill, Md. 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	Donna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3MP

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dey	Year	3. Time of Death
ETHEL	A	BROWN	MAY	17	2002	1:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SNOW HILL NURSING AND REHABILITATION	SNOW HILL	WORCESTER

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-32-9377	1☐ M 2☒ F	93 Yrs.					MAY 11, 1909	MARYLAND

Funeral Director

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5186 SANBORN TERRACE	21801	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	REGISTERED NURSE	HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES PERCY ARRINGTON	GRETA MARSHALL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
GRETTA B. CROCKETT - DAUGHTER	5186 SANBORN TERRACE SALISBURY, MD 21801

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CHESTERFIELD CEMETERY	5/20/02	CENTREVILLE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ B. Keith [illegible] CFSP	705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Dementia	3 yrs.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CVA; CAD,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Jarrod	D54422	5-17-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
430- W. Market St.; Snow Hill; MD 21863

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[illegible]

To the Hospital or Attending Physician: Tha law requiras thet the death certificete be axecuted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely fillad in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Ethel A. Brown SS # 220-32-9377 / CTB: 5-17-02 @ 0135 DOB 5-11-09

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
David Phillip Bosley-Smith	May 20, 2002	1:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
937 Walnut Wood Road	Hunt Valley	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-52-4321	1☒M 2☐F	52 Yrs.			Dec. 19, 1949	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Hunt Valley	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
937 Walnut Wood Road	21030	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Assistant Treasurer	Spice Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Francis Bosley-Smith	Elizabeth Dolores Gutowski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Dennis J. Smith (personal-admin.)	508 Hanna Road, Bel Air, MD 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Highview Mem'l Gard.	5/24/02	Fallston, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Mark T. Zavagno	Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic cardiovascular disease	20 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD Deputy	D18667	May 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Phillip Militello, 6 Trimble Hill Ct., Lutherville, MD 21093

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
MAY 22 2002	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jacqueline Yvonne Ballistreri

2. Date of Death: Month 5 Day 18 Year 02

3. Time of Death: 11:15 PM

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-50-3375

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 15, 1948

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 4317 Glenmore Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse

16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): James C. Preston

18. Mother's Name (First, Middle, Maiden Surname): Rosalie Wilkenson

19a. Informent's Name/Reletionship (Type, Print): Santo B. Ballistreri/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4317 Glenmore Avenue, Baltimore, Md. 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Parkwood Cemetery

Date: 5/21/02

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Carol Baumberg

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Cardiac Arrest — 1 day

Due to (or as a consequence of):

b. Acute Myocardial Infarction — 1 Day

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: N. A.

23b. **Did tobacco use contribute to the causa of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: C E Araraga

29c. License number: D000-383

29d. Date signed (Month, Day, Year): May 20th 02

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): CARLOS E. ARAHAGA, M.D., 3007 E. Northern Parkway, Baltimore Md. 21214

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrer's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pagas 1 end 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiana. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquires thet the death certificete be executed within 24 hours after daath.
To the Funeral Director: After this certificete has baan signed by tha attanding physician end completaly filled in by tha funaral diractor, paga 2 should ba datechad for usa as tha burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item #24a per VERBAL G8086/6/02 EM

Certificate of Death

Reg. No. 2002 18169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
REGINALD T BLAIR	MAY 26 2002	0925 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Howard County General Hospital	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~578~~ 60 3386	1 [X] M 2 [ ] F	55 Yrs.			~~Apr~~ MAR 15, 1947	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Laurel	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9230 Traders Crossings Apt N	20723	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Shuttle Bus Operator	Beltway Transportation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Blair	Mamie Davis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Beverly Blair/Wife	7781 Montgomery ~~Mews~~ MEWS Ct Severn MD 21144

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metro Crematory	5-29-2002	Catonsville, MD

21. Signature of Funeral Service Licensee: [signature] M01142

22. Name and Address of Facility: Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

22a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Paraplegia hypertension

23e. Did tobacco use contribute to the cause of death? ~~1 [ ] Yes~~ 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes ~~2 [ ] No~~	Hospital: ~~1 [ ] Inpatient~~ 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
~~1 [ ] Natural~~ 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
~~1 [ ] Certifying Physician:~~ To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D28998	May 29 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM S SAINI MD
9101 Cherry Lane Suite 211 Laurel MD 20708

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
ERNEST J. COLLINS, SR.	May	22	2002	2237 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FORT WASHINGTON HOSPITAL	FORT WASHINGTON	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222 18 2185	1☒ M 2☐ F	68 Yrs.			April 13, 1934	Delaware

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Camp Springs	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5001 Colonial Drive	20748	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	☒ Yes 2☐ No If Yes, Give Year or Dates: 1962	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Retail Management	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Elwood Collins	Helen Cannon

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred Collins /wife	5001 Colonial Drive Camp Springs, MD 20748

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Veterans Cem	May 29, 2002	Cheltenham, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kimberly Chuccetonic	Marshall's Funera Home 4308 Suitland Road Suitland, MD 20746

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☑ Yes 2☐ No	Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D46741	May 22, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Deepak Sachdeva, M.D. 11711 Livingston Road, Fort Washington, MD 20744

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10) 1/4

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Grace G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18171

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Thomas Carroll
2. Date of Death — Month: May, Day: 17, Year: 2002
3. Time of Death: 4:00am
4e. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home
4b. City, Town, or Location of Death: Landover
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-40-9193
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 23, 1921
9. Birthplace *(State or Foreign Country)*: Annapolis, Md.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 6808 Valley Park Rd.
10f. Zip Code: 20743
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: William Carroll
18. Mother's Name *(First, Middle, Maiden Sumame)*: Lillie Snowden

19a. Informant's Name/Relationship *(Type, Print)*: Jan M. Carroll / Son
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 6808 Valley Park Rd. Capitol Heights, Md. 20743

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Arlington National
Date: 5/23/02
20c. Location - City or Town, State: Arlington, Va.

21. Signature of Funeral Service Licensee: Keith A. Savage MD 085
22. Name and Address of Facility: Alexander S. Pope Funeral Homes, 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Metastatic Prostate Cancer — 4yrs
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*
Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier
29c. License number: D32261
29d. Date signed *(Month, Day, Yeer)*: 5-17-02

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Richard J. Feldman MD 9500 Annapolis Rd, Lanham MD 20706

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 2 4 2002
32. Registrer's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter deeth.
To the Funeral Director: After this certificete hes been signed by the attending physician end completely filled in by the funerel director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CR (5)

Markis Lee Coloman
02-2566-033
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18172

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Markis L. Coleman	May 18 2002	12:22 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2100 Block Shady Side Avenue	Capitol Heights	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-08-7641	1 X M 2 F	17 Yrs.			5/22/84	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George	Capital Heights	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1809 Arcadia Avenue	20743	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify: Black	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Student	High School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Phillip Coleman	Donnalee Hardy

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donnalee Hardy-Coleman/Mother	1809 Arcadia Ave., Capital Heights MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Harmony Mem	5/25/02	Landover,Maryland

21. Signature of Funeral Service Licensee: William R. Berger

22. Name and Address of Facility: Robert G. Mason Funeral Home, 1661 Good Hope Rd SE, Wash DC 20020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 No	1 X Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 X Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	5-15-02	00:08 M	1 Yes 2 X No	passenger auto fixed object collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Roadway	2100 Block Shady Side Ave

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	May 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CR

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Rosalie	Caldwell	May 19, 2002	1805 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
243-68-8257	1☐M 2☒F	60 Yrs.			March 8,1942	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
632 Fairview Avenue, Apt 1	21502	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		waitress	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Miller Rudasill Grim	Anna Frances (Reynolds)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pat Donahue / sister	11321 Morning Side Dr., NE, Cumberland, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cumberland Crematory	5/20/02	Cumberland, MD

21. Signature of Funeral Service Licensee: Robert C. Adams

22. Name and Address of Facility: Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung CANCER.	>1Yr.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD, DVT, Metastasis from Lung CA.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Shiv Khanna	D 0054004	May 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIV KHANNA, M.D. 625 KENT AVE. CUMBERLAND, MD. 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

MD

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Dey	Year	3. Time of Death
ANNIE ELIZABETH CANTLER	MAY	22,	2002	0400

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CITIZEN'S NURSING HOME	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthdey)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign Country)
217-12-9584	1☐ M 2☒ F	85 Yrs.					AUG. 2, 1916	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	FREDERICK	FREDERICK	1☒ Yes 2☐ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
1900 ROSEMONT AVENUE	21702	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Educetion (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5	0	HOMEMAKER	OWN HOME

17. Fether's Neme (First, Middle, Lest)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH MEEK THOMPSON	EMMA JANE HOBACK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
MARLINE A. FRIEND, DAUGHTER	5525 FERRERO LANE, KEEDYSVILLE, MARYLAND 21756

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	RESTHAVEN MEM. GARDENS	MAY 24, 2002	FREDERICK, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Paul M. Dean	BAST FUNERAL HOME 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death)	a. Acute myocardial infarction	minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Yeer)
▶	D0031058	5-24-02

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)
GENE F. ASHE, MD 10200 Coppermine Road, PO Box 6 Woodsboro, MD 21798

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
MAY 24 2002	▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#16b Per FH 5/20/2002 HCHD LM **Certificate of Death**

Reg. No. 2002 18175

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL CARVELL, Jr.
2. Date of Death: Month 5 Day 17 Year 2002
3. Time of Death: 8:06am
4a. Facility Name (If not institution, give street and number): Mt. Washington Pediatric Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215-13-3839
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 15 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-4-1986
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE CITY
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1708 WEST ROGERS AVENUE
10f. Zip Code: 21209
10g. Citizen of What Country?: U.S

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NONE
16b. Kind of Business/Industry: ~~NOT APPLICABLE~~ None

17. Father's Name (First, Middle, Last): MICHAEL CARVELL, Sr
18. Mother's Name (First, Middle, Maiden Surname): AMY DAVIS

19a. Informant's Name/Relationship (Type, Print): Mrs.Amy L. Davis/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 943 Redfield Road, Bel Air, Maryland 21014

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 05/20/02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Christina L. David
22. Name and Address of Facility: The Schimunek Funeral Home, 610 West MacPhail Road, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Severe chronic lung disease and tracheomalacia
Due to (or as a consequence of):
b. Multiple congenital anomalies.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hyperostosis-primary involving cranium
Hydrocephalus with VP shunt, seizure disorder
History of ASD, VSD and renal tubular acidosis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year): Not Applicable
28b. Time of Injury: M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D41411
29d. Date signed (Month, Day, Year): 5-17-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ajoke Ajayi-Akintade, M.D., 1708 West Rogers Avenue, Baltimore, MD 21209

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
HAWA	DABA	May 21, 2002	4:45p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRINGS	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
Unavailable	1☐M 2☒F	35 Yrs.			June 10,1966	Sierra Leone

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Geo.	Lanham	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9933 Greenbelt Rd.	20706	Sierra Leone

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Unavailable	Unavailable

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
AlHaji Shehu Daba	Hadja Hafsa Bella Daba

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sulaiman Daba- Brother	10016 Vanderbilt Cir.#5,Rockville,Md.20850

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	George Wash Cemet.	5-22-02	Adelphi,Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dave Al Mateen	Universal II Mortuary Inc. 411Kennedy St,N.W.,Washington,D.C.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Uterine Sarcoma	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0027550	05/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RICHARD FOOTER,M.D. 4808 Moorland La.#103,Bethesda,Maryland 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (1)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18177

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harvey J. Dyck
2. Date of Death (Month, Day, Year): May 18, 2002
3. Time of Death: 9:50 A
4a. Facility Name *(If not institution, give street and number)*: 6710 Birch Lane
4b. City, Town, or Location of Death: Temple Hills,
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 517 01 8287
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 22, 1918
9. Birthplace *(State or Foreign Country)*: Montana

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1 [ ] Yes 2 [X] No XX
10e. Street and Number: 6710 Birch Lane
10f. Zip Code: 20748
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married XX 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No XX *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver/ Sales
16b. Kind of Business/Industry: Retail Route Sales

17. Father's Name *(First, Middle, Last)*: Jacob W. Dyck
18. Mother's Name *(First, Middle, Maiden Surname)*: Katherine Geisbrecht

19a. Informant's Name/Relationship *(Type, Print)*: Olive Dyck (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6710 Birch Lane, Temple Hills, MD 20748

20a. Method of Disposition: 1 [X] Burial XX 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery — May 23, 2002
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Mark D. Parker
22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ADENOCARCINOMA OF PANCREAS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Terence Bertele
29c. License number: D30041
29d. Date signed *(Month, Day, Year)*: 5/20/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Terence Bertele, M.D. 12070 Old Line Ceneter#303, Waldorf, Maryland 20602

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 22 2002
32. Registrar's Signature: Barbara B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (6) 16

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Russell	E.	Day Sr.	May 17, 2002	1031 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-18-1547	1 X M 2 F	78 Yrs.			Aug 17, 1923	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	Carpendale	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13 Buddy Lane	26753	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Construction Worker	Local 616

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Calvin M. Day	Bessie V (Saville)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Lavin daughter	643 National Highway; LaVale MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Hillcrest Memorial Par	5/20/2002	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James T Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	10 Minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Artery Disease	10 Years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure, Nephrotic Syndrome,

Anemia, Gastrointestinal Bleeding

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
N. A. Ranjithan	D19318	May 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nagaratnam Ranjithan, 517 Oldtown Road, Cumberland, Maryland 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Barbara G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

YES

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AnnaMay Davis

2. Date of Death (Month, Day, Year): May 19 2002

3. Time of Death: 11:15 AM

4a. Facility Name (If not institution, give street and number): Allegany County Nursing & Rehab Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-2382

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 7,1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Flintstone

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 11105 Frank Davis Road NE

10f. Zip Code: 21530

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Christian Smith

18. Mother's Name (First, Middle, Maiden Surname): Josephine James

19a. Informant's Name/Relationship (Type, Print): Emory L. Davis,Jr. Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14410 Amcelle St., Cresaptown,MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview Christian Cem.

Date: May 23,2002

20c. Location - City or Town, State: Near Artemas,PA

21. Signature of Funeral Service Licensee: Douglas S Hafer

22. Name and Address of Facility: Hafer Funeral Service P.A. 1302 National Hwy, LaVale, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approx. Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBROVASCULAR ACCIDENT — 9 MOS,

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robustiano J. Barrera Jr.

29c. License number: D-14865

29d. Date signed (Month, Day, Year): MAY 19TH 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Robustiano V. Barrera, Memorial Ave., Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002

32. Registrar's Signature: Geraldine D Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquiras that the death certificata ba executed within 24 hours afar death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely fillad in by tha funeral director, page 2 should be detached for usa as tha burial-transit

10

YMS

Medical Certification: To Be Completed by Physician/Medical Examiner

Amended # 19a, mlo, 5/21/02, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18180

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John Carson Dowell	May 20, 2002	12:00P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
329-09-6062	1☒M 2☐F	92Yrs.			Nov 13, 1909	Missouri

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Cumberland	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1037 Bishop Walsh Road	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5	Sales Manager	Tire/Rubber Co.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Dowell	Effie Creech

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary ~~Low~~ Lou Dowell Wife	1037 Bishop Walsh Rd.,Cumberland,MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Silbaugh Crematory	May 22,2002	Uniontown, PA

21. Signature of Funeral Service Licensee ▶ Douglas D. Hafer

22. Name and Address of Facility
Hafer Funeral Service, P.A.
1302 National Hwy, LaVale, MD 21502

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. End Stage Renal failure — Approximate Interval Between Onset and Death: one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Diffuse Arteriosclerotic Vascular disease — 2yrs

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Gary Wagoner MD

29c. License number D22181

29d. Date signed (Month, Day, Year) MAY 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR GARY WAGONER, 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year) MAY 21 2002

32. Registrar's Signature ▶ Teresa G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18181

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOHN MICHAEL DELANEY	May 19 2002	3:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215 12 2486	1 X M 2 ☐ F	80 Yrs.			MAY 28, 1921	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ALLEGANY	FROSTBURG	X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
167 WEST MAIN STREET	21532	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		QUALITY CONTROL INSPECTOR	BALLISTICS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FRANK DELANEY	EVELYN YENSHAW

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARY SUSAN DELANEY / DAUGHTER	12 CENTENNIAL STREET, FROSTBURG, MD 21532

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	FROSTBURG MEMORIAL PARK	5/22/02	FROSTBURG, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SOWERS FUNERAL HOME, P.A. 60 WEST MAIN STREET, FROSTBURG, MD 21532

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — Approximate Interval: months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dehydration
pleural effusion
superior vena caval syndrome

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature], MD	D03459	May 20 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. ESPINA MD 902 Seton Drive, Cumberland

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Deputy G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18182

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
MARY ALMA DUDLEY	MAY 27, 2002	8:05 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SACRED HEART HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-38-7314	1☐M 2☒F	91 Yrs.			AUG. 13, 1910	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	ALLEGANY	LAVALE	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
19 RICHARD WAY	21502	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	TEACHER	EDUCATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PATRICK E. CONROY	ANNIE FANNON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILLIAM C. DUDLEY, JR. / SON	15509 WINSLOW ST., S.W. - CUMBERLAND, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	ST. MICHAEL'S CEM.	05/30/2002	FROSTBURG, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Glenda M. Upchurch	UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET - CUMBERLAND, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEMORRHAGIC BRAIN CANCER	FOUR MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ JM Moen MD	D33417	MAY 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES R. MOEN, MD 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15 pee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18183

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ELVA MAE DODSON	MAY 21 2002	0210 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
226-30-9089	1☐M 2☒F	75 Yrs.			August 30, 1926	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Hagerstown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2245 Beverly Drive	21740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Cave	Ruth Cave

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Harman / Son	11211 Hollywood Road, Hagerstown, Md. 21740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Haven Cemetery	5/25/2002	Hagerstown, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Md. 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RESPIRATORY FAILURE	HOURS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. SEVERE EMPHYSEMA	1½ YEARS
	Due to (or as a consequence of): c. CIGARETTE SMOKING	DECADES
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ FAMILY PHYSICIAN	D1706	MAY 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEPHEN E. HEGEVER, MD 747 DUNCANNON AVE HAGERSTOWN, MD 21742

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dodson, Elva Mae MRN 1180297

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18184

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
MILDRED LONG DULIN	MAY	13	2002	2234 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-12-1503	1 ☐ M 2 ☒ F	78 Yrs.			5/01/24	DELAWARE

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DELAWARE	SUSSEX	DAGSBORO	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
R.D. 1 BOX 236	19939	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: X	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		HOMEMAKER	HOMEMAKING

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
THOMAS J. FISHER	AMY E. HUDSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
WILLIAM F. DULIN / HUSBAND	R.D. 1 BOX 236, DAGSBORO, DE 19939

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	REDMEN'S CEMETERY	5/17/02	SELBYVILLE, DE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Richard F. Watson	WATSON FUNERAL HOME, MILLSBORO, DE 19975

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN, DM, CHF

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D42913	MAY 15, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUNNAR H. ZORN, M.D. 100 E CARROLL ST. SALISBURY, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	▶

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18185

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
EDMUND	T.	DELANEY	MAY	17	2002	8:26 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
208 HALL DRIVE	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
019-28-2515	1[X] M 2[ ] F	65 Yrs.			OCT. 13, 1936	MASSACHUSETTS

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
208 HALL DRIVE	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	COLLEGE PROFESSOR	SALISBURY UNIVERSITY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH R. DELANEY	JANE E. BURKE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
EDMUND G. DELANEY -- SON	202 HALL DR. SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	PARSONS CEMETERY	5/21/2002	SALISBURY, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic lung Cancer	2 mo
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[X] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[X] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D 20507	5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph A. GRASSO 145 E. CURROW ST SALISBURY MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 17 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18186

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
SAMUEL R DENNIS	MAY 11 2002	8:22A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
BALTIMORE VA MEDICAL CENTER	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-30-8027	1 X M 2 F	68 Yrs.			3-9-34	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	WICOMICO	SALISBURY	1 ☐ Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6158 WESTBURY ACRES	21801	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates: Korea Vietnam	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		U.S. AIRFORCE	U.S. MILITARY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PAUL E. DENNIS	PAULINE BURBAGE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PAUL DENNIS BROTHER	PO BOX 72 TYASKIN, MD 21865

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ARLINGTON CEMETERY	6-11-02	ARLINGTON, VA

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
Lyndwood D. Messick	M00-417	Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 30 minutes

Immediate Cause (Final disease or condition resulting in death): a. PULMONARY EMBOLISM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of): COPD

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	P13416	MAY 11 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHAIM VANEK 10 NORTH GREENE ST. BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 2002	Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

19+1VADQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#9 perFHG808 6/7/02 EW

Certificate of Death

Reg. No. 2002 18187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Chettie May Dumler

2. Date of Death: Month: May; Day: 15; Year: 2002

3. Time of Death: 3:28 pm

4e. Facility Name (If not institution, give street end number): The Gilchrist Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-34-2225

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/08/1938

9. Birthplace (State or Foreign Country): ~~West Virginia~~ Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 622 Silver Bell Drive

10f. Zip Code: 21040

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Stenographer

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Lest): August W. Lind

18. Mother's Name (First, Middle, Maiden Sumame): Goldie Ruth Bowden

19a. Informent's Name/Reletionship (Type, Print): Daniel J. Dumler / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 622 Silver Bell Drive Edgewood, Maryland 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Pk.

Date: 5/18/02

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark T. Bo

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Maryland 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: if item 27 le marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5.15.02 3:28 pm

Dumler, Chettie

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. OVARIAN CANCER — years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Yeer): MAY 16, 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 2120X

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002

32. Registrar's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#25.PerME/PGC 5-20-02 cr

Certificate of Death

Reg. No. 2002 18188

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NAOMI SMITH EARLE
2. Date of Death Month: May Day: 13 Year: 2002
3. Time of Death: 6:15A M
4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 120-16-9480
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 21, 1924
9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5410 76th Court
10f. Zip Code: 20784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk Division of Housing
16b. Kind of Business/Industry: Civil Service

17. Father's Name (First, Middle, Last): Edward Smith
18. Mother's Name (First, Middle, Maiden Surname): Edwortha Trotman

19a. Informant's Name/Relationship (Type, Print): Wendy Greenlee - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5410 76th Court, Hyattsville, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery
Date: 05/18/2002
20c. Location - City or Town, State: Bronx, New York

21. Signature of Funeral Service Licensee: ▶ Alph W. Miller
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Diverticulitis, Chronic — 3 years

Due to (or as a consequence of):
b. Recurrent Gastrointestinal bleeding — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Amended Death, DC FH 005592 D.M.E.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Alzeheimer
Burns with Skin grafting

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes ~~2☒ No~~
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Moustafa Shamma, MD
29c. License number: D43690
29d. Date signed (Month, Day, Year): 5/13/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Moustafa Shamma MD 515 Main Street Suite 253 Laurel Md 20707

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Naomi Smith EARLE

CR (5)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
ROBERT		EVERITT	MAY 22 2002	20:06 PM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
JOHNS HOPKINS BAYVIEW	BALTIMORE		Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-28-6636	1 [X] M 2 [ ] F	70 Yrs.			Dec. 14, 1931	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington	Clear Spring,	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11865 Boyd Road	21722	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 1958-1960	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	0	Machine Operator	Railroad

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Lewis H. Everitt	Mary L. Moore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patsy A. Everitt wife	11865 Boyd Rd. Clear Spring, MD 21722

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Shanktown Cemetery	May 28, 2002	Big Pool, MD

21. Signature of Funeral Service Licensee: Craig M. Cole

22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc 13607 National Pike Clear Spring, MD 21722

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multisystem Organ Failure	4 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): 63% Total Body Surface Area Burns	10 DAYS
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEPSIS

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	MAY 13 2002	6:00 PM	1 [ ] Yes 2 [X] No	BURN AFTER LIGHTING LEAVES ON FIRE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 11865 BOYD ROAD, CLEAR SPRING, MARYLAND

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Carmen Cozart	RES-000	MAY 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CARMEN COZART 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	Benjamin G. Spratley

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EW

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18190

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Bryan Flaherty
2. Dete of Death (Month, Dey, Year): May 22, 2002
3. Time of Death: 6:10 a.m.
4e Fecility Neme (If not institution, give street end number): 8319 Stanwood Street
4b. City, Town, or Location of Death: New Carrollton
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 012-12-3087
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. lest birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 20, 1923
9. Birthplece (State or Foreign Country): Massachusetts

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 8319 Stanwood Street
10f. Zip Code: 20784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Rocket Scientist
16b. Kind of Business/Industry: NASA

17. Father's Name (First, Middle, Lest): John B. Flaherty, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Grace Darling Duley

19a. Informant's Name/Relationship (Type, Print): Marjorie M. Flaherty - Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8319 Stanwood Street, New Carrollton, MD 20784

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 05/22/02
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Hypertension
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest:
b. Cerebrovascular Disease
Due to (or es e consequence of):
c. Benign Prostate Hypertrophy
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D34722
29d. Date signed (Month, Day, Yeer): May 22, 2002

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Vicken K. Poochikian, M.D., 5632 Annapolis Road, #3, Bladensburg, MD 20710

State Registrar

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CR 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18191

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Fernandez
2. Date of Death (Month, Day, Year): May 18, 2002
3. Time of Death: 7:12 PM
4a. Facility Name (If not institution, give street and number): Fort Washington Hospital
4b. City, Town, or Location of Death: Ft. Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 207-26-1133
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-28-1933
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1715 Taylor Avenue
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952-1974
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [X] Yes 2 [ ] No Specify: Spaniard
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): U.S. AirForce
16b. Kind of Business/Industry: Military

17. Father's Name (First, Middle, Last): Jesus Fernandez
18. Mother's Name (First, Middle, Maiden Surname): Christina Franciasia

19a. Informant's Name/Relationship (Type, Print): Dorothy Fernandez - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1715 Taylor Avenue Fort Washington, Maryland 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington Nat'l. Cemetery
Date: 06/11/2002
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Joyce P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardiopulmonary Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
b. End Stage Liver Cancer

Due to (or as a consequence of):
c. Sepsis

Due to (or as a consequence of):
d. Clostridium Difficile Colitis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dehydration

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samuel J. Kleiman MD
29c. License number: D26262
29d. Date signed (Month, Day, Year): 5/19/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMUEL J. KLEIMAN 11711 Livingston Road Ft Washington MD 20744

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: Joyce B. Sparks

CR 10

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Dean Thomas Fogle
02-2583-043
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18192

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Dean Thomas Fogle	May	18	2002	11:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Route 40 near St. Paul Road	Clearspring	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-60-8321	1☒M 2☐F	36 Yrs.					Feb. 16, 1966	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington Co.	Clear Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
13226 Blairs Valley Road	21722	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Contractor	Self employed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Richard Fogle	Regean P. Wiles

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alan L. Fogle/Brother	13301 National Pike, Clear Spring, MD 21722

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Grossnickle C.O.B. Cemetery	May 22	Myersville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Douglas A Fiery	Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	5-18-02	2213 M	1☐Yes 2☒No	Driver auto - fixed object collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Roadway	Rt 40

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	May 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Regina G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18193

FLAGG, DARLENE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

2 DQ

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DARLENE MINENNA FLAGG
2. Date of Death (Month, Day, Year): May 17, 2002
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): SALISBURY REHAB AND NURSING CENTER
4b. City, Town, or Location of Death: SALISBURY, MD.
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-70-7005
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 43 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-7-59
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6616 TRUITT ST
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STOCKER
16b. Kind of Business/Industry: PEPSI COLA

17. Father's Name (First, Middle, Last): JAMES HENRY PURNELL
18. Mother's Name (First, Middle, Maiden Surname): MARJORIE FARMER

19a. Informant's Name/Relationship (Type, Print): ARTHUR FLAGG ~ HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6616 TRUITT ST. - SALISBURY, MD. 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ZION CHURCH CEMETERY
Date: 5/25/02
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: BENNIE SMITH F/H
917 W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure — year
Due to (or as a consequence of):
b. Need Hemodialysis — year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as e consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D-29349
29d. Date signed (Month, Day, Year): 5/20/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM ROBINS, M.D.,1104 HEALTHWAY DR.,SALISBURY, MD 21804

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18194

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS M. FENDER

2. Date of Death: Month MAY Day 21st Year 2002

3. Time of Death: 04:13 AM

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-24-1513

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/19/1928

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Pylesville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 602 St. Mary's Road

10f. Zip Code: 21132

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Robert Meeks

18. Mother's Name (First, Middle, Maiden Surname): Florence (unknown)

19a. Informant's Name/Relationship (Type, Print): Thomas E. Fender - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 St. Mary's Rd., Pylesville, md 21132

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Date: 5/24/02

20c. Location - City or Town, State: Pylesville, MD

21. Signature of Funeral Service Licensee: Jeffrey P. Lovelace

22. Name and Address of Facility: Harkins F.H.Inc., 600 Main St., Delta, PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Right Lower Lobe Pneumonia

Approximate Interval Between Onset and Death: 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetaf death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Streptococcus Pneumoniae Bacteremia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0056607

29d. Date signed (Month, Day, Year): MAY 21st, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH ANGELO, #1, 2112 BELAIR ROAD, FALLSTON, MD 21047

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Doris Marie Fender

LM

16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18195

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William E. Green	May 15, 2002	8:00p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
245-78-1318	1☒M 2☐F	53 Yrs.			March 19 1949	North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DC		Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5225 Dix St. N.E. #102	20019	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Parking Attendant	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Slade Green	Ruebell Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dionne M. Glenn/Daughter	5225 Dix St. N.E. #102 Washington DC 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Olivet Cemetery	5/22/02	Washington DC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Talonia H. Lewis	Alexander S. Pope Funeral Home 2617 Pennsylvania Ave S.E. Washington DC 20020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hyperkalemia	Unknown
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Renal failure	"
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☑No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rointan Farahfar MD	D43446	5/16/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROINTAN FARAHFAR M.D 9801 Georgia Ave Suit 335 Silver Spring MD 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

1

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Green, William expired @ 2000 5-15-02

CR (1)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg No. 2002 18196

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria Gleaton

2. Dete of Deeth: Month: May; Dey: 13; Year: 2002

3. Time of Death: 2:37PM

4e Fecility Neme (If not institution, give street end number): Holy Cross Hospital

4b. City, Town, or Location of Deeth: Silver Spring

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 578-52-9907

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): May 12, 1940

9. Birthplace (State or Foreign Country): Wash., DC

Usuel Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 531 Powhatan Place, N.W.

10f. Zip Code: 20011

10g. Citizen of What Country?: United States

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Private

17. Fether's Neme (First, Middle, Last): Crogher Butler

18. Mother's Name (First, Middle, Maiden Surname): Alice Montgomery

19a. Informant's Name/Relationship (Type, Print): Robert D. Gleaton - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 531 Powhatan Place, N.W. Wash., DC 20011

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Lee's Crematory | Date: 5/25/2002

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Neme and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic cardiovascular heart disease

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Congestive heart faulure, diabetes mellitus, hypertension, chronic renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and plece, and due to the cause(s) end menner steted.

29b. Signature end title of certifier: Robert H Gerard MD

29c. License number: MD #0055522

29d. Date signed (Month, Dey, Yeer): May 13, 2002

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Robert H. Gerard, MD 1500 Forest Glen Rd., Silver Spring, MD 20910

State Registrar

31. Dete filed (Month, Dey, Yeer): MAY 24 2002

32. Registrer's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CR (2)

Amended #15, nls, 05/22/02, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jean Getty	May 15, 2002	11:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Country House Residence	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-24-8745	1 ☐ M 2 ☒ F	74 Yrs.			November 02, 1927	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Lonaconing	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
80 East Main Street	21539	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Ellsworth Gardner	Dollie Mae Wilt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Reba Niland-Daughter	706 Braddock Avenue, LaVale, Maryland 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cumberland Crematory	May 16, 2002	Cumberland, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jana E. McKee	Eichhorn-McKenzie Funeral Home P.A., Lonaconing, Md. 21539

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's Dis	6 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A J Bollino MD	D0017565	May 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A J Bollino MD 922 Nat'l Hwy LaVale MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 17 2002	▶ G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18198

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Henry	J.	Guthrie	May 16, 2002	02:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-24-8716	1 ☐ M 2 ☐ F	72 Yrs.			Jul 19, 1929	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Rawlings	1 ☐ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
P.O. Box 322--Llewellyn Avenue	21557	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Local 616

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George T. Guthrie	Anna (Dixon)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ethel Durst niece	107 South Street; Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Waxler Cemetery	5/18/2002	Rawlings, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Severe Congestive Heart Failure 1 week

Due to (or as a consequence of):
b. Coronary disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung Cancer
pulm. emphysema

23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
R Espina, MD	D03459	May 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R. ESPINA, MD 902 Seton Dr, Cumberland Md

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Brenda G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
SHIRLEY LOUISE GROSSNICKLE	May 25, 2002	5:05AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-50-2661	1☐ M 2☒ F	61 Yrs.			Apr. 26, 1941	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington Co.	Smithsburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
22329 Cave Hill Road	21783	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Cafeteria Manager	Board of Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Elmer Bernard Funk	Ruth Valentine Sines

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Keith W. Grossnickle/Son	212 S. Potomac St., Waynesboro, PA 17268

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Lawn Mem. Park	May 29	Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery

22. Name and Address of Facility: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ovarian Carcinoma	6 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Frederick Klein MD	D23623	May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Klein MD 11110 Medical Campus Rd Hagerstown MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	Jessica G. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Grossnickle, Shirley Louise

DHMH 17 Rev 1/2001

ORIGINAL

Otis C. Hollis
02-2565-033
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #17&18 PER EH G810 8/13/02 JH

1- For State Registrar **AMEND ITEM#3 per ME G808 070202 ss** UNPENDED 060702:ITEMS#23a,27 per ME G808 ss

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2002 18200

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Otis Carl Hollis

2. Date of Death: Month: May; Day: 17; Year: 2002

3. Time of Death: 22:11 pm ~~10:11 A~~ M

4a. Facility Name (If not institution, give street and number): Malcolm Grow Hospital

4b. City, Town, or Location of Death: Andrews Air Force Base

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 379-74-4163

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 22, 1959

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6102 Walnut Street

10f. Zip Code: 20748

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): U.S. Marines-Staff Sargeant

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): OTIS HOLLIS ~~Otis C. Hollis, Sr.~~

18. Mother's Name (First, Middle, Maiden Surname): MAE ~~Annie May~~ Baldwin

19a. Informant's Name/Relationship (Type, Print): Rosalind Hollis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8843 Heathermore Blvd.,#302 Upper Marlboro, MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Memorial Park

Date: 5-25-2002

20c. Location - City or Town, State: Belleville, Michigan

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SARCOIDOSIS OF HEART, LUNG, LYMPH NODE AND SPLEEN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): May 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 2 1 2002

32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18201

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Lorraine Helms	May 13 2002	3:14 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of maryland medical	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-74-7435	1☐M 2☒F	49 Yrs.			11-08-1952	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	P.G.	Greenbelt	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6010 Srping Hill Dr. #103	20772	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Security	Security Exchange Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Kelly Mosley	Elizabeth Harvey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michelle Simms-Helms Daughter	5111 Fitch St SE #304 Wash,DC 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	5-17-02	Alexandria, VA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Austin Royster Funeral Home 3821 14th ST NW Washington, DC 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Peritonitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AIDS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Cary Burger D.O.	AU417643SB13741	May 13 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street, Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	[signature]

CK (10)

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edna Lorraine Hebrew
2. Dete of Deeth (Month, Dey, Year): May 21, 2002
3. Time of Death: 11:45 pm
4a Fecility Name (If not institution, give street end number): 6207 Sargent Road
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215-34-3026
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): December 5, 1918
9. Birthplace (State or Foreign Country): Harrison, Arkansas

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 6207 Sargent Road
10f. Zip Code: 20782
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Private Business

17. Fether's Name (First, Middle, Last): Wayne A. Simpson
18. Mother's Name (First, Middle, Maiden Surname): Eula Baker Wiggins

19a. Informant's Name/Relationship (Type, Print): Alan N. Hebrew - Spouse
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 6207 Sargent Road, Hyattsville, Maryland 20782

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 5/23/02
20c. Location - City or Town, State: Alexandria,Virginia

21. Signature of Funeral Service Licensee: Robert O May
22. Name and Address of Fecility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Pert I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Terminal Alzheimer's Disease — 5 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Bed Sores

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Tsunie Chanchien
29c. License number: D 13339
29d. Date signed (Month, Day, Year): May 22, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Tsunie Chanchien, M.D., 8824 Cunningham Dr., Ste. A, Berwyn Heights, MD 20740

State Registrar

31. Date filed (Month, Day, Year): MAY 2 4 2002
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours aftar daath with tha Maryland Dapartmant of Haalth and Mantal Hygiana.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquiras that tha daath cartificata be axacutad within 24 hours aftar daath.
To the Funeral Director: Aftar this cartificata has baan signad by tha attanding physician and completely filled in by tha funaral diractor, paga 2 should be datachad for usa as tha burial-transit

CR 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Delores	Harris	May 16 2002	2037 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-50-7080	1☐ M 2☒ F	65 Yrs.			Dec 13,1936	Washington DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George	Capital Heights	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1219 Quo Avenue	20743-2074	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th	2	Clerk	Retail Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herbert Harris	Bertha Gaines

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Phyllis Lucas/Sister	1219 Quo Ave., Capital Heights, MD 20743-2074

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	5/23/02	Alexandria, VA

21. Signature of Funeral Service Licensee: William R. Boyce

22. Name and Address of Facility: Robert G. Mason Funeral Home, 1661 Good Hope Rd SE, Wash DC 20020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE PULMONARY EMBOLISM	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
UPPER GASTROINTESTINAL BLEEDING

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D 53885

29d. Date signed (Month, Day, Year): 5/17/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
VENKAT S RAMAVAN 5701 SURRATTS ROAD #307 CLINTON MD 20735

State Registrar

31. Date filed (Month, Day, Year): MAY 2 4 2002

32. Registrar's Signature: Barbara D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Ramivan
5/16 10a @ 2037
Delores, Harris
CR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #1&11 PER PHY&INF.G808 6/11/02 JH

Certificate of Death

Reg. No. 2002 | 8204

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
~~Paul Oliver Hart~~ PAUL OLIVIER HART		05 / 15 / 2002	7:52am

4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
Prince Georges Hospital	Cheverly	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
560-74-3276	1☒ M 2☐ F	62 Yrs.			03/09/1940	Jamaica

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Mitchellville	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1801 Manorfeild Court	20721	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
~~1☒~~ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Zoning Specialist	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Hart	Maude L. Heron

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Azan/Niece	6902 Highview Terrace #301 Hyattsville, MD 20782

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Riverdale Crematory	5-22-02	Riverdale, MD

21. Signature of Funeral Service Licensee: ▶ K.D. Marshall

22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Rd., Landover, Md 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Renal Failure	5 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Nephrolithiasis	2 yrs
	Due to (or as a consequence of):	
	c. Diabetes Mellitus II	10 yrs
	Due to (or as a consequence of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Hyperlipemia

Hypertension

23b. **Did tobecco use contribute to the cause of deeth?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ David R. Brown MD	D36784	May 17 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David Brown, MD 7610 Carroll Ave Suite 300 Takoma Park, MD 20912

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 2 0 2002	Barbara B. Sparks

CR 6

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law raquires that the death certificate be axecutad within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by tha funaral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18205

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Teresa Hall
2. Date of Death (Month, Day, Year): May 16, 2002
3. Time of Death: 2:44 a M
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-44-7258
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1932
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Mt. Rainier
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4113 Rainier Avenue
10f. Zip Code: 20712
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Clay Carr Peyton
18. Mother's Name (First, Middle, Maiden Surname): Mary Catherine Green

19a. Informant's Name/Relationship (Type, Print): Anthony M. Hall - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4113 Rainier Avenue, Mt. Rainier, MD 20712

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: 05/18/2002
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Henry L. Faul
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARRYTHMIA — 5mts

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Cerebrovascular accident — 2wks.
Due to (or as a consequence of):
c. Sepsis. — 2wks
Due to (or as a consequence of):
d. Hypertension.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus. Renal failure
Coronary artery disease
Cancer of Thigh.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D19609.
29d. Date signed (Month, Day, Year): MAY, 17th, 2002.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMAN R. TULI, MD 3503 PERRY STREET, MOUNT RAINIER. MD

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner may be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Ann Harvey

2. Date of Death (Month, Day, Year): 05-15-2002

3. Time of Death: 7:15 AM

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 414-69-4725

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 13, 1928

9. Birthplace (State or Foreign Country): Liberia

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery County

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 2956 Gracefield Road

10f. Zip Code: 20904

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): Stephen Moore

18. Mother's Name (First, Middle, Maiden Surname): Mary Ann Green

19a. Informant's Name/Relationship (Type, Print): Muriel Diggs- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2956 Gracefield Road Silver Spring, MD 20904

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gates of Heaven Cemetery

Date: 05/25/02

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: D.C. Taylor

22. Name and Address of Facility: Taylor's Funeral Home 1722 North Capitol Street, NW WDC 20001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA SENILE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Mallory

29c. License number: D42403

29d. Date signed (Month, Day, Yeer): 5/15/02

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): RAJ MATHUR 106 IRVING STREET, NW WASHINGTON D.C

CR (6)

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrer's Signeture: B. Hanks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Vincent M. Height
CJ
02-2464-033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18207

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Vincent Martin Height, Jr.	May	11	2002	08:30 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
rear of 11563 Laurel Walk Drive	Laurel	P G County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-96-4671	XX 1 M 2 F	24 Yrs.					11-10-1977	Washington, DC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	P G County	Clinton	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8408 Mimosa Avenue	20735	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Driver	Private Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Vincent Martin Height, Sr.	Delena Howard

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vincent Martin Height, Sr.	5234 Daventry Terrace Forrestville, MD 20747

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mt. Olivet Cemetery	5-17-2002	Washington, DC

21. Signature of Funeral Service Licensee: Shyllett Bryant

22. Name and Address of Facility: Taylor's Funeral Home 20001, 1722 North Capitol Street, NW Washington, DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. 2 Gunshot wounds to head

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 X Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Scene

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 X Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 5-11-02

28b. Time of Injury 8:28 M

28c. Injury at Work? 1 Yes 2 X No

28d. Describe how injury occurred: Deceased Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street

28f. Location (Street and Number or Rural Route Number, City or Town, State) 11563 Laurelwalk Dr.

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	May 12, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	B. Sparks

CR (4)

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the **Hospital** or **Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#5. PerFH PGC 5-29-02 cr

Certificate of Death

Reg. No. 2002 18208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL E. HENLEY JR.

2. Date of Death: Month MAY Day 20 Year 2002

3. Time of Death: 5:39 PM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 219-56-1379

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 8 1957

9. Birthplace (State or Foreign Country): California

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Seabrook

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 9501 Tuckerman St.

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married XX 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No XX If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Flight Controller

16b. Kind of Business/Industry: SAIC

17. Father's Name (First, Middle, Last): Paul E. Henley Sr.

18. Mother's Name (First, Middle, Maiden Surname): Audrey Dean

19a. Informant's Name/Relationship (Type, Print): Mercedes Henley (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9501 Tuckerman St. Seabrook, MD 20706

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Tanglewood Cemetery

Date: 5/24/02

20c. Location - City or Town, State: Linville, NC

21. Signature of Funeral Service Licensee: Julian Rendon

22. Name and Address of Facility: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. BRAIN HERNIATION SYNDROME — Approximate Interval Between Onset and Death: 12 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. RUPTURED CEREBRAL ANEURYSM — 24 hours

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward D Ahn MD

29c. License number: P14630

29d. Date signed (Month, Day, Year): MAY 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD AHN, MD DEPT OF NEUROSURGERY, 22 S. GREENE ST., BALTIMORE, MD 21201

CR (10)

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: Brenda B. Sacks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18209

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Salem Humbertson Jr.
2. Date of Death (Month, Day, Year): May 15 2002
3. Time of Death: 11:50PM M
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 220-10-1401
6. Sex: 1 X M 2 F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 5, 1919
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 X Yes 2 No
10e. Street and Number: 522 Riehl Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 X Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner
16b. Kind of Business/Industry: Ideal Window Co.

17. Father's Name (First, Middle, Last): Salem Humbertson, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth (Bond)

19a. Informant's Name/Relationship (Type, Print): Gregory A. Humbertson son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14821 Viewcrest Road SW;Cresaptown MD 2150

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rocky Gap Veterans Cem
Date: 5/20/2002
20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: James V Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Closed head injury — 10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Presious CVA
C O P D

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 X Yes 2 No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day Year): 5/5/02
28b. Time of Injury: 10:55PM M
28c. Injury at Work? 1 Yes 2 X No
28d. Describe how injury occurred: patient fell and hit head
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Nursing home
28f. Location (Street and Number or Rural Route Number, City or Town, State): Lions Manor Nursing home

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Paul Snow
29c. License number: D 09157
29d. Date signed (Month, Day, Year): May 16 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow, M.D. Dpty Med Ex 124 w 3rd St Cumberland Md 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 17 2002
32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Charles Norman Hanekamp, Sr.	May 22, 2002	1445 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-28-9451	1☐M 2☐F X	69 Yrs.			Oct 12, 1932	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☐Yes X 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
306 Bellvue Heights	21502	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1952-52	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Brewery

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Albert Hanekamp	Elsie Marie (Humphrey)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Loretta Hanekamp / wife	213 Independence St., Cumberland, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rocky Gap Veterans	5/28/02	Flintstone, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert C. Adams	Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Probable Cardiac Arrhythmia	1/2 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Coronary artery disease	5 years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D0033280	May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunil K. Gupta, M.D. 625 Kent Avenue, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit (VA).

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 | 8211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Blair	Junior	Hardman	May	27	2002	1713 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
14501 Hardman Rd	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-24-1228	1[X] M 2[ ] F	74 Yrs.					Oct 24, 1927	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1[ ] Yes 2[X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
14501 Hardman Rd	21502	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yes, Give Year or Dates:	1[ ] Yes 2[X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
3		Custodian	Public School

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Blair Hardman	Martha Jane (Blubaugh)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dolores I. Hardman / wife	14501 Hardman Rd., Cumberland, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Sunset Memorial	5/30/02	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert C. Adams	Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Lung — 2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1[ ] Yes 2[ ] No 9[ ] Unknown	1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) 9[ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1[X] Yes 2[ ] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA Other: 4[ ] Nursing Home 5[X] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0033280	May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sunil K. Gupta, M.D. 625 Kent Avenue, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18212

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald Lindbergh Harne

2. Date of Death: Month May Day 27 Year 2002

3. Time of Death: 18:52 P M

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 215-26-7967

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 3, 1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 108 E. Baltimore St.

10f. Zip Code: 21740

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 53-55

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Charles O. Harne

18. Mother's Name (First, Middle, Maiden Surname): Carrie Kuhn

19a. Informant's Name/Relationship (Type, Print): Garnetta L. Harne (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 E. Baltimore St. Hagerstown, Md. 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garfield U.M. Cemetery

Date: May 30, 2002

20c. Location - City or Town, State: Garfield, Md.

21. Signature of Funeral Service Licensee: Dennis L. [illegible]

22. Name and Address of Facility: Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia — 2 days

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Amyloidosis

Chronic renal insufficiency

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D0054451

29d. Date signed (Month, Day, Year): May 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Brian Bonham 3019 Ventrie Court Myersville, md

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Peggy	Gladys	Hill	May	16	2002	06:20P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
103 Whayland Drive	Hebron	Wicomico

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☐F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-38-2370	X	60 Yrs.			March 15, 1942	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Hebron	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
103 Whayland Drive	21830	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7	---	Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willard E. Tull	Gladys -- Tilghman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Teresa L. Reed-Daughter	103 Whayland Drive, Hebron, MD 21830

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Union UM Church Cem.	5/20/2002	Salisbury, MD

21. Signature of Funeral Service Licensee: ▶ Keith A Dewey CFSP

22. Name and Address of Facility: Holloway Funeral Home, Professional Association 501 Snow Hill Road, Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Metastatic Breast Cancer Bone, Brain	6 mos.
Due to (or as a consequence of): b.	Carcinoma of the Breast Recurrent	1990's
Due to (or as a consequence of): c.	Carcinoma of the Breast	20yrs
Due to (or as a consequence of): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D24986	5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert J. Reilly MD 560 Riverside Dr. Salisbury Md. 21801

JMP

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	▶ Denise B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18214

CARROLL HASTINGS 222-10-4437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
CARROLL	LEE	HASTINGS	MAY 12 2002	10:01 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-10-4437	1 ☒ M 2 ☐ F	78 Yrs.			December 17, 1923	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1602 South Kaywood Drive	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	-	Salesman	Automobile

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John S. hastings	Lillian W. (unknown)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elva E. Hastings/Wife	1602 S. kaywood Dr., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Wicomico Memorial Park	5/16/02	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kelly A Dewey CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LONGSTANDING HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CARDIOGENIC SHOCK

Due to (or as a consequence of):

c. ASCVD

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ DJ Chodnicki	020912	5/12/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis J. Chodnicki MD 400 EASTERN Shore Dr. Salisbury, Md.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 2002	▶ Brenda D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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12+1 VA DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18215

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beatrice Katherine Horky

2. Date of Death — Month: May; Day: 17; Year: 2002

3. Time of Death: 4:15 pm

4e. Facility Name *(If not institution, give street end number)*: Mariner Health of Bel Air

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-05-8461

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Dey, Yeer)*: April 16, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 800 St. Andrews Way

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*

Elementery/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Executive Secretary

16b. Kind of Business/Industry: City Government

17. Father's Name *(First, Middle, Lest)*: Rudolf Frank Horky

18. Mother's Name *(First, Middle, Maiden Sumeme)*: Josephine Marie Kalal

19a. Informant's Name/Relationship *(Type, Print)*: Diane Horky Dixon / Niece

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 3945 Prospect Road, Street, MD 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Francis de Sales Cem.

Date: 5-21-02

20c. Location - City or Town, State: Abingdon, Maryland

21. Signature of Funeral Service Licensee: Shelley M. Remington

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final diseese or condition resulting in deeth)

a. Ovarian Cancer — years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*: NA

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: MD

29c. License number: D 39889

29d. Date signed *(Month, Day, Yeer)*: May 18 2002

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): ALFRED SPARKS 615 W. MARSHALL RD BEL AIR MD 21014

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 21 2002

32. Registrer's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Beatrice K. Horky

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Shirley L. Iverson	May 13, 2002	3:55A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-36-6350	1☐M 2☒F	73 Yrs.			Aug. 27, 1928	Wash., D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	P.G.	Lanham	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10021 Greenbelt Rd. #303	20706	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Nannie	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Leroy Iverson	Ella Ashton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sylvester Thompson Sr.	1227 Larchmont Avenue Capitol Heights, MD. 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resurrection Cem.	5/23/02	Clinton, MD.

21. Signature of Funeral Service Licensee: Leroy Hodges

22. Name and Address of Facility: Hodges & Edwards F.H. 3910 Silver Hill RD., Suitland, MD. 20746

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. DIABETIC NEPHROPATHY	5 YRS.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY HEART DISEASE

PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ed Rosenbaum	D09834	5/13/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BARRY ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD 20895

CR (2)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Eugene B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#19b.PerFH PGC5-24-02 cr

Certificate of Death

Reg. No. 2002 18217

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EUNICE LOUISE JONES
2. Date of Death (Month, Day, Year): MAY 18, 2002
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): 7600 GREEN WILLOW COURT
4b. City, Town, or Location of Death: LANDOVER
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 454-58-2039
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): JULY 13, 1940
9. Birthplace (State or Foreign Country): TEXAS

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGES
10c. City, Town or Location: LANDOVER
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7600 GREEN WILLOW COURT
10f. Zip Code: 20785
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 1 YEAR
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHERS ASSISTANT
16b. Kind of Business/Industry: KENNEDY INSTITUTE

17. Father's Name (First, Middle, Last): JOE ALLEN
18. Mother's Name (First, Middle, Maiden Surname): LOUISE ROGERS

19a. Informant's Name/Relationship (Type, Print): DIANE JONES / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7600 GREEN WILLOW ~~WAY~~ Court LANDOVER, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RESSURECTION CEM.
Date: 05-24-2002
20c. Location - City or Town, State: CLINTON, MARYLAND

21. Signature of Funeral Service Licensee: Juawana L Braxton
22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MARYLAND 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Ovarian Cancer — Due to (or as a consequence of): — 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sajeev Anand M.D.
29c. License number: D-33482
29d. Date signed (Month, Day, Year): May 22nd, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sajeev Anand, M.D. 7343 HANOVER PARKWAY GREENBELT, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature:

CR 16

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT JOHNSON

2. Date of Death: Month May, Day 12, Year 2002

3. Time of Death: 1:55AM

4a. Facility Name (If not institution, give street end number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 579-12-6124

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): April 2, 1920

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: MD

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 6334 Cedar Lane

10f. Zip Code: 21044

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): unknown

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: Navy Department

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Mary Webley/Guardian Specialist

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5012 Rhode Island Ave., Hyattsville, MD @)&*!

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 05/17/02

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ Joyce Montgomery - Chris Horn

22. Name and Address of Facility: CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Pneumonia — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Azotemia

Ventilatory Failure

Atrial Fibrillation

23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edward W. Schaefer, Jr. M.D.

29c. License number: D18457

29d. Date signed (Month, Dey, Year): May 20, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Edward W. Schaefer, Jr. M.D. 11055 Little Patuxent Pkwy., Columbia, MD 21044

of (2)

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002

32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18219

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lynne Maureen JAMISON
2. Date of Death Month Day Year: May 27, 2002
3. Time of Death: 7:50 p.m.

4a. Facility Name (If not institution, give street and number): 634 Highland Way
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-90-8458
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 19,1963
9. Birthplace (State or Foreign Country): Rhode Island

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 634 Highland Way
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 1
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): high school career counselor
16b. Kind of Business/Industry: Washington County Board of Education

17. Father's Neme (First, Middle, Lest): Norman C. St. Jean, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Patricia Lemoi

19a. Informant's Name/Relationship (Type, Print): Bryan D. Jamison - husband
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 634 Highland Way, Hagerstown, Md. 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Lawn Mem. Park
Date: 5/31/02
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service License: Scott Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Non Hodgkin's Lymphoma — 1 1/2 years
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b. Due to (or es e consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: M. J. Cormack M.D.
29c. License number: 041667
29d. Date signed (Month, Day, Year): 5/28/02

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Michael McCormack 11110 Medical Campus Hagerstown MD.

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 29 2002
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law raquires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18220

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janice Renee JOHNSON
2. Date of Death (Month, Day, Year): May 25, 2002
3. Time of Death: 2:00 a.m.
4a. Facility Name (If not institution, give street and number): 18443 Horseshoe Bend Road
4b. City, Town, or Location of Death: Sharpsburg
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 212-72-7427
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 25, 1959
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Sharpsburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 18443 Horseshoe Bend Road
10f. Zip Code: 21782
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): secretary
16b. Kind of Business/Industry: auto body repair

17. Father's Name (First, Middle, Last): Arthur R. Wolfe, Sr.
18. Mother's Neme (First, Middle, Maiden Surname): Janet Anderson Rice

19a. Informant's Name/Relationship (Type, Print): Michael Johnson - husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18443 Horseshoe Bend Road, Sharpsburg, Md. 21782

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hagerstown Crematory
Date: 5/28/02
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Scott Minnich
22. Name and Address of Facility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Small Cell lung Cancer — 8 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as e consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Frederick H Kass III M.D.
29c. License number: D23623
29d. Date signed (Month, Day, Yeer): May 28, 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Frederick H Kass III M.D. 11110 medical Campus Rd Hagerstown maryland 21742

State Registrar

31. Dete filed (Month, Day, Year): MAY 29 2002
32. Registrer's Signature: Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18221

JONES, KELTON

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
KELTON	LEE	JONES	May	11	2002	3:50 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Wicomico Nursing Home	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-14-1616	1☒ M 2☐ F	84 Yrs.					April 24, 1918	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
900 Booth Street	21801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Business Accountant	US Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Lee Jones	Alice Parker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Susan J. Johnson/Daughter	7649 Cedartown Rd., Snow Hill, MD 21863

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parsons Cemetery	5/16/02	Salisbury, MD

21. Signature of Funeral Service Licensee ▶ David A. Thompson CFSP

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D55006	MAY 13, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mohan Bhat MD 614 EasternShore Drive Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 2002	▶ Benna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10+1VA DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerald Durwood Kifer

2. Date of Death: Month MAY, Day 14, Year 2002

3. Time of Death: 15:35 M

4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 174-34-9747

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/18/1941

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: PA

10b. County: Bedford

10c. City, Town or Location: Artemas

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 340 Lashley Road

10f. Zip Code: 17211

10g. Citizen of What Country? US

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 71-73

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Operator

16b. Kind of Business/Industry: State Govenment

17. Father's Name (First, Middle, Last): Harry Franklin Kifer

18. Mother's Name (First, Middle, Maiden Surname): Eulah Faye (Collins) Kifer

19a. Informant's Name/Relationship (Type, Print): Heather Kifer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 340 Lashely RD, Artemas, PA 17211

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview Christian Cem. Date: 05/18/02

20c. Location - City or Town, State: Ingelsmith, PA

21. Signature of Funeral Service Licensee: Robert C. Adams

22. Name and Address of Facility: Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO-PULMONARY ARREST — 6-7 HOURS

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION — 6-7 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

STATUS POST CORONARY ARTERY BYPASS GRAFT, HYPERTENSION, OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Suresh Shrestha

29c. License number: D20258

29d. Date signed (Month, Day, Year): MAY 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH M. SHRESTHA, 600 MEMORIAL AVE., CARDIOLOGY DEPT., CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 17 2002

32. Registrar's Signature: Donna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ROY ROBERT KING	May 18, 2002	1727 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON COUNTY HOSPITAL	HAGERSTOWN	WASHINGTON

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-50-5522	1 [X] M 2 [ ] F	52 Yrs.			7/10/1949	VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	BERKELEY	MARTINSBURG	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
267 KODIAK DRIVE	25401	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		MAINTENANCE ENGINEER	MARYLAND STATE HIGHWAY ADMINISTRATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN KING	LORENA EVANS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FILIMORA KING/WIFE	267 KODIAK DR., MARTINSBURG, WV 25401

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	SMITHSBURG CREMATORY	MAY 21, 2002	SMITHSBURG, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Charles M Brown	BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING STREET MARTINSBURG, WV 25401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction. — 1D

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0056413	5/20/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SAXENA, 3 BYRKIT DRIVE, WILLIAMSPORT, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	Barbara G. Spradley

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Edwin W. Kern
02-2683-033
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Edwin W. Kern	May	23	2002	12:38 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
196-16-9182	1☒M 2☐F	77 Yrs.			1/8/1925	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Adams	Fayetteville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
31 Hill Crest Road	17222	US

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Unknown		Letter Carrier	US Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Luther Kern	Emma Leinart

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judith Wagner Kern - Wife	31 Hill Crest Road Fayetteville,PA 17222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Smithsburg Crematory	5/25/02	Smithsburg, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Dennis L. Davis	Davis Funeral Home 12525 Bradbury Avenue Smithsburg, MD 21783

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MOTOR VEHICLE ACCIDENT

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	5-23-02	11:32 M	1☐Yes 2☒No	Deceased's vehicle struck by car

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): SB Route 495 N.O/Temple Hills Rd.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] M.D.	O.C.M.E.	May 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18225

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EDWINA BELLE KAUFFMAN	MAY 18 2002	7:10 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
145 FRANCIS DRIVE	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-20-0504	1☐M 2☒F	76 Yrs.			FEB. 8 1926	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
145 FRANCIS DRIVE	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No *Specify:*	*Specify:* WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	SALES ASSOCIATE	PHARMACY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
PARKER JENKINS	GENOA BANKS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ROBERT KAUFFMAN - HUSBAND	145 FRANCIS DRIVE SALISBURY MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	SILOAM CEMETERY	5/22/2002	SILOAM, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
B. Kent Lynn CFSP	705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Cancer Unknown Prim	2 mos
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D26278	5-20-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DAVID COLLAZ, M.D. 1456 Carroll St Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Dey / Year	3. Time of Death
JOHN W. KOHLBUS	MAY 18 2002	08:30HR

4a Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
3901 PROSPECT RD	STREET	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
219-18-0253	1 XM 2 F	77 Yrs.			9/25/1924	Maryland

Usuel Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Street	1 Yes 2 XX No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
3901 Prospect Road	21154	USA

11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	1 XX Yes 2 No If Yes, Give Year or Dates:	1 Yes XX No Specify:	Specify: White

15. Decedent's Educetion (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Supervisor	Civil Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William H. Kohlbus	Bessie Mary Flaharty

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
Lenora A. Kohlbus- wife	3901 Prospect Rd., Street, MD 21154

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mt. Vernon Cemetery	5/21/2002	Whiteford, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John D. Talbott	Harkins F.H. 600 Main St., Delta, PA 17314

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

LM

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. MASCVD	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 Yee 2 XX No 3 Probably 4 Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 XX No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Menner of Death	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Naturel 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.
2 X **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
DME	OCME	MAY 18, 2002

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print)
95 PRABHU M.D. 2336 YORK RD TIMONIUM MD 21093

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18227

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alberta Mary Lloyd
2. Date of Death Month Day Year: 5/17/2002
3. Time of Death: 7:10 aM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-58-6618
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-25-1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 1706 East 29th Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist
16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Charlotte Lloyd

19a. Informant's Name/Relationship (Type, Print): Michelle Morgan Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1706 East 29th Street Baltimore, MD 21218

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory
Date: 5/21/2002
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: B C Taylor
22. Name and Address of Facility: Taylor's Funeral Home 1722 North Capitol Street, NW Washington DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Hypoxia — Approximate Interval Between Onset and Death: 30min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of): b. Respiratory Difficulty — 1 1/2 hrs
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes ☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ian Chuang
29c. License number: D0057192
29d. Date signed (Month, Day, Year): May 23, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ian Chuang, M.D. Union Memorial Hospital Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): MAY 2 4 2002
32. Registrar's Signature: Bernice G. Sparks

CR 6

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18228

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Sylvester Lemieux	May 15, 2002	4:40 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Ft. Washington Hospital	Ft. Washington	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
437-58-6899	1☒ M 2☐ F	61 Yrs.			Jan. 24, 1941	New Orleans, La.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	FT. Washington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12241 Arrow Park Dr.	20744	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No 9/29/60 If Yes, Give Year or Dates: 9/28/62	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Clerk	U.S. Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ignes Joseph Lemieux	Ezell Celistan

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley A. Lemieux / Wife	12241 Arrow Park Dr. Ft. Washington, Md. 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Veterans	May 22, 2002	Cheltenham, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Keith A. Sawyer M01085	Alexander S. Pope Funeral Homes 5538 Marlboro Pike/ Forestville, Md. 20747

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b. Respiratory Failure

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d. CVA

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0046374	May 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11701 Livingston Road #207 Ft Washington MD 20744

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Sandra L. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (4)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Marcelle	Louise	LeRoux	May 21, 2001	8:25 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11002 Queen Anne Ave.	Beltsville	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
070-28-7085	1☐M 2☒F	74 Yrs.			Feb.22,1928	France

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Beltsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11002 Queen Anne Avenue	20705	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9		Waitress	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Louis Kergoat	Anne Bloch

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paul Y. LeRoux - Husband	11002 Queen Anne Avenue Beltsville, Maryland 20705

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	5/22/2002	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald V. Borgwardt	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Carcinoma Bladder Metastatic	
a. Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Due to (or as a consequence of):		
c. Due to (or as a consequence of):		
d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D19220	May 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neil A. Meade, M.D. 9811 Mallard Drive Laurel, Maryland 20708

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	[signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CC (8)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18230

THOMAS G. LINDNER 214-42-0609

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Thomas Gary Lindner
2. Date of Death (Month, Day, Year): MAY 24, 2002
3. Time of Death: 16:30 M
4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY
5. Social Security Number: 214-42-0609
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1943
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 518 Regina Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sergeant
16b. Kind of Business/Industry: MD State Police
17. Father's Name (First, Middle, Last): Thomas William Lindner
18. Mother's Name (First, Middle, Maiden Surname): Marguerite Tyler
19a. Informant's Name/Relationship (Type, Print): M. Emilie Lindner wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Regina Avenue;Cumberland MD 21502
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park
Date: 5/28/2002
20c. Location - City or Town, State: Cumberland, MD
21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIAC ARRYTHMIA — MINUTES
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ARTERIOSCLEROTIC HEART DISEASE — YEARS
Due to (or as a consequence of):
c. DIABETES MELLITUS — YEARS
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
BILATERAL CEREBROVASCULAR ACCIDENTS,
BILATERAL HEMIPLEGIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No
25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check one) Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Beverly M Calkins MD
29c. License number: D0054411
29d. Date signed (Month, Day, Year): MAY 24, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CALKINS, BEVERLY M., M.D., 500 MEMORIAL AVENUE, SUITE 105, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Elwood Lashley	MAY 27, 2002	17:30PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-20-5290	1☒M 2☐F	77 Yrs.			24-Jul-23	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Frostburg	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
57 Washington Street	21532-	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	0	machinist helper	railroad

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Benjamin Lashley	Lillian Norris

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Ruth Lashley wife	57 Washington Street	Frostburg	Maryland	21532-

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Lawn Memorial Gardens	30-May-02	LaVale, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John R. Durst	Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D3607606	MAY 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR VIKRAMADITYA POONAI, 924 SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18232

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harvey Clinton Leisinger Sr.
2. Dete of Death Month / Day / Year: May 21, 2002
3. Time of Death: 7:40PM
4e Fecility Name *(If not institution, give street end number)*: Julia Manor Health Care Center
4b. City, Town, or Location of Deeth: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 213-18-8179
6. Sex: 1☒M 2☐F
7. Age *(In yrs. lest birthdey)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 22, 1914
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 13157 Kaiser Ridge Road
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10th / College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Trainman
16b. Kind of Business/Industry: Rail Road

17. Father's Name *(First, Middle, Last)*: Herbert Alexander Leisinger
18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Catherine Miner

19a. Informant's Name/Relationship *(Type, Print)*: Mildred P. Leisinger / Wife
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 13157 Kaiser Ridge Road Hagerstown, MD 21740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Lawn Memorial Gdns.
Date: 5/24/02
20c. Location - City or Town, State: Hagerstown, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac St. Hagerstown, MD 21740

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia — 3 weeks

Due to (or as a consequence of):
b. Congestive Heart Failure — yrs

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Arteriosclerotic Cardiovascular Disease — yrs

Due to (or es e consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Renal insufficiency

23b. **Did tobacco use contribute to the cauee of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D18019
29d. Date signed *(Month, Day, Year)*: MAY 22, 2002

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Vasant Datta, M.D., 334 Mill Street, Hagerstown, MD 21740

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 24 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Ian Lawrence Leatherman
02-2534-043
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Ian Lawrence Leatherman	May	16	2002	12:50 A M

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11226 Marburn Road	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-15-0306	1☒M 2☐F	22 Yrs.			Mar. 9, 1980	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington Co.	Hagerstown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11226 Marbern Road	21740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Laborer	Grocery Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Dennis L. Leatherman	Sharon L. Noland

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles E. Noland, Jr./Uncle	18807 Rolling Road, Hagerstown, Maryland 21740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Smithsburg Crematory	May 23	Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Douglas A. Fiery

22. Name and Address of Facility: Douglas A.Fiery Funeral Home, 1331 Eastern Blvd., N., Hagerstown, MD 21742

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

20a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. multiple gunshot wounds to chest and right arm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined	05-15-2002	1845 M	1☐Yes 2☒No	Deceased shot by brother in home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 11226 Marburn Road Hagerstown, Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	May 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For Stete Registrar

Reg. No. 2002 18234

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
DAVID	JEFFERSON	LARMORE	MAY	14	2002	0048 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-90-8194	1☒M 2☐F	32 Yrs.					May 6, 1970	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
403 Gunby Road	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	–	Professional Volunteer	Health Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Sheldon Larmore	Sara Belle Jefferson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James S. Larmore/Father	403 Gunby Rd., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Wicomico Memorial Park	5/17/02	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith R. Drury CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Spinda bifida
chronic urinary tract infection

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital:	Other:
1☐Yes 2☒No	1☐Inpatient 2☒ER/Outpatient 3☐DOA	4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D30853	5/14/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles B. Silvia, Jr MD 100 Power Street Salisbury MD 21804

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 2002	▶ Jeanne G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DAVID LARMORE 324 # 216-90-8194 5/14/02 0048

6 DQ

Per E.W.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18235

Grace Landry 220 66 3678

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
GRACE	EUSTACE	LANDRY	5 / 14 / 2002	1136 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-66-3678	1☐ M 2☒ F	78 Yrs.			November 7, 1923	Maine

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
700 Regency Drive	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Registered Nurse	Health Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Edward Talbot	Kathern Waterhouse

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dr. Armand J. Landry/Husband	700 Regency Dr., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Salisbury Crematory	5/15/02	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
David A. Thompson, CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	20 mins
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): HyperKalemia	2 hrs.
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☑ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) N/A 9☐ Unknown	N/A Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☑ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Benito S. Chan, MD	D-20050	5/14/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENITO S. CHAN 547-G Riverside Dr. Salisbury, MD 21801

10 DQ

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 16 2002	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George M. Lawrence
2. Date of Death (Month, Dey, Year): May 18, 2002
3. Time of Death: 1:50 AM
4e. Facility Name (If not institution, give street and number): Oak Crest Care Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 296-12-2372
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 2, 1910
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 8810 Walther Blvd., Apt. 225
10f. Zip Code: 21234
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Administrator
16b. Kind of Business/Industry: Ohio State University

17. Fether's Neme (First, Middle, Last): Lewis Lawrence
18. Mother's Name (First, Middle, Maiden Surname): Gertrude (Surname Unknown)

19a. Informant's Name/Relationship (Type, Print): Mrs. Joan D. Lawrence (wife)
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 8810 Walther Blvd., Apt. 225, Parkville, MD 21234

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory, Inc.
Date: 5/20/02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Brian A. Miller
22. Name and Address of Facility: Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

GEORGE M. LAWRENCE 5/18/02 0150

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Arteriosclerotic cardiovascular disease — yrs.

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kendall Faulkner
29c. License number: D25643
29d. Date signed (Month, Day, Year): 05/20/2002

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): KR Faulkner MD / 8800 Walther Blvd / Balto MD 21234

To the Hospital or Attending Physician: Tha law requires that tha death certificata be executed within 24 hours aftar death.
To the Funeral Director: Aftar this certificata has been signed by tha attending physician and completaly filled in by tha funaral director, paga 2 should be datached for usa as tha burial-transit

Division of Vital Records, P.O. Box 68760, GEORGE M. LAWRENCE 5/18/02 0150

State Registrar

31. Date filed (Month, Dey, Year): MAY 20 2002
32. Registrer's Signeture: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

Certificate of Death

Reg. No. 2002 18237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
RAYMOND MARTIN	MAY	19	2002	2.00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. AGNES HOSPITAL	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-70-4650	1☒M 2☐F	50 Yrs.					May 23, 1951	Washington,D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1223 Kent Ave.	21207	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Laborer	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Morris Martin	Florence Lark

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carolyn Lark / Sister	12615 Lagrange Ct. Ft. Washington, Md. 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Resurrection Cem.	May 25,2002	Clinton, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith A. Jarvis 401015	Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. BRAIN STEM CEREBROVASCULAR ACCIDENT — DAY

Due to (or as a consequence of):
b. HYPERTENSIVE CRISIS — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ B Bonme MD	P13595	MAY 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEORGE BAFFOE-BONNIE. ST. AGNES HOSPITAL, BALTIMORE

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Barbara B. Apatis

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME RAYMOND MARTIN

CR (4)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
EDITH	MILES	MAY 15, 2002	10:40P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHERN MARYLAND HOSPITAL	CLINTON	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-30-0253	1☐ M 2☒ F	78 Yrs.			FEB. 15, 1924	VIRGINIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGES	CAPITAL HEIGHTS	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4319 SOUTHERN AVENUE	20743	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	RETIREMENT CLERK	FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
THOMAS HALSEY	MARIE NICHOLAS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CHARLES MILES/HUSBAND	4319 SOUTHERN AVE. CAPITAL HEIGHTS, MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	FT. LINCOLN CEMETERY	5/22/02	BRENTWOOD, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD. BRENTWOOD, MD 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SMALL BOWEL OBSTRUCTION

Due to (or as a consequence of):

c. SMALL BOWEL LOOPS AROUND THE OMENTUM

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

INFECTIOUS DIARRHEA

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	50454	5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARASTOO YAZDANI M.D. 9801 GEORGIA AVE. #3-35 SILVER SPRING, MD 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event. If a Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

CC (4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For Stete Registrar

Reg. No. 2002 18239

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth A. Mitchem
2. Date of Death (Month, Day, Year): May 17, 2002
3. Time of Death: 11:06 aM
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 234-44-5149
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 8, 1930
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4529 Maple Avenue
10f. Zip Code: 20814
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: KOREAN
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Stock Person
16b. Kind of Business/Industry: Restaurant Industry

17. Father's Name (First, Middle, Last): Wilbur R. Mitchem
18. Mother's Name (First, Middle, Maiden Surname): Mami M. Doyle

19a. Informant's Name/Relationship (Type, Print): John Cymbalisty - Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3720 Parkwood Street, Cottage City, MD 20722

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 05/22/2002
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert C May
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hemorrahagic Shock

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Ruptured Aneurysm of Aorta — 1 day

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Acute Ischemia of the Bowels

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Alberto Nunez MD
29c. License number: D07597
29d. Date signed (Month, Day, Year): May 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L. Alberto Nunez, M.D., 8218 Wisconsin Avenue, Bethesda, Maryland

State Registrar

31. Date filed (Month, Day, Year): MAY 2 4 2002
32. Registrar's Signature: Bonnie B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0036
Division of Vital Records, P.O. Box 68760,

5/17/02 @ 11:06AM Mitchem, Kenneth

CR 2

02-2595-017
mnmr
Tommy Marsh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18240

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Tommy Marsh	May 19, 2002	17:48p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Crain Highway @ BelAlton Newtown Road	Bel Alton	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
237-33-6122	1☒M 2☐F	37 Yrs.			Nov 8, 1964	Monroe NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George	Temple Hills	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2803 Keith St #102	20748	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Barber	Brice's Barber Shop

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Harry Tommy Marsh	Genora Covington

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Genora C. Marsh/Mother	1921 17th St SE #2, Washington DC 20020

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hillcrest Cemetery	5/25/02	Monroe, NC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
William R. Boggs	Robert G. Mason Funeral Home 1661 Good Hope Rd SE, Wash DC 20020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	5/19/02	1738 PM	1☐Yes 2☑No	MOTORCYCLE Operator Impacts Fixed Objects

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street	Crain Highway Charles County, Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner, M.D.	O.C.M.E.	May 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	[illegible]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (6)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #17 PER FH G810 8/28/02 JH

Certificate of Death

Reg. No. 2002 18241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Canfield Moran
2. Date of Death (Month, Day, Year): May 22, 2002
3. Time of Death: 2:50P M
4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 178-01-7416
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 5,1909
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Crofton
10d. Inside City Limits: ☒Yes 2☐No
10e. Street and Number: 2131 Davidsonville Road
10f. Zip Code: 21114
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Religious

17. Father's Name (First, Middle, Last): John William ~~Canefield~~ CANFIELD
18. Mother's Name (First, Middle, Maiden Surname): Mary Coyne

19a. Informant's Name/Relationship (Type, Print): Rosemary Marquette-Dtr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1809 Huntcreek Run, Gambrills, Md. 21054

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St.Patrick Cemetery; Date: 05-28-02
20c. Location - City or Town, State: Pottsville, Pa.

21. Signature of Funeral Service Licensee: Robert O Beall
22. Name and Address of Facility: Beall Funeral Home, 6512 N.W. Crain Hwy., Bowie, Md. 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

1 week

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard K Schultz Jr.
29c. License number: D35848
29d. Date signed (Month, Day, Year): May 24,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard K Schultz Jr. 1438 Defense Hwy Gambrills MD 21054

State Registrar

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: Barbara G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

CR (7)

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18242

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Jeanetta L. Maines

2. Dete of Deeth: Month May Day 22, Year 2002

3. Time of Death: 11:01 a.m.

4a Fecility Neme (If not institution, give street end number): Prince George's Hospital Center

4b. City, Town, or Location of Deeth: Cheverly

4c. County of Deeth: Prince George's

5. Social Security Number: 200-26-2931

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): October 18, 1931

9. Birthplace (State or Foreign Country): Kentucky

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bladensburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 5309 Upshur Street

10f. Zip Code: 20710

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): John William Phillips

18. Mother's Name (First, Middle, Maiden Surname): Audrey L. Burrows

19a. Informant's Name/Relationship (Type, Print): Susan J. Floyd - Daughter

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 5309 Upshur Street, Bladensburg, Maryland 20710

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 5/23/02

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Robert C Mac

22. Name and Address of Fecility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): e. Cor Pulmonale.

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular Disease. Heart failure Rt-sided, Cardiopulmonary Arrest. Anoxic Encephalopathy, Cirrhosis of liver. Pneumonia.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death (Check only one) Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Neelam Ashra M.D.

29c. License number: D48213

29d. Date signed (Month, Dey, Year): 05-23-02.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Neelam Ashra 4410 74th Ave. Landover Hills MD 20784.

State Registrar

31. Date filed (Month, Dey, Year): MAY 24 2002

32. Registrer's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Jeanetta Maines 05/22/02

CR (2)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Josephine Mitchell	May 18, 2002	10:35P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
231-30-6061	1☐ M 2☒ F	99 Yrs.			Sept. 29, 1902	Alabama

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.		Washington, D.C.	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4601 Martin Luther King Ave. SW.	20032	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Housewife	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
James W. Tucker	Annabell Davis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Anna Mott/Niece	5636 Onslow Way, Capitol Heights, MD. 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Harmony Memorial Park	May 24, 2002	Landover, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith A. Savage M0108	Pope Funeral Homes, 5538 Marlboro Pike Forestville, MD. 20747

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Bronchopneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

Acute Renal Failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0055120	May 18 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Palmer MD 1328 Southern Ave SE Suite 310 Washington DC 20032

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18244

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
EDWARD		MITCHELL	May 11 2002	1855 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
080-03-6409	1☐M 2☐F	86 Yrs.			Oct 15, 1915	Columbia SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George	Suitland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6101 Carswell Terrace	20746	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Sixth		Carpenter	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jessie Mitchell	Ella Kirkland

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jeffrey Clark/Grandson	44008 Kings Arms Square, Ashburn, VA 20146

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒1 Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Hill	5/20/02	Suitland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John F Bolden	Robert G. Mason Funeral Home 1661 Good Hope Rd SE, Wash DC 20020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

CEREBROVASCULAR ACCIDENT

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D53885	5/13/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VENKAT S RAMAVAN MD 7501 SURRATTS ROAD #307 CLINTON MD 20735

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Lorraine G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18:55 @ 5/11/02

Mitchell, Edward

CR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ann McKie	May 22, 2002	3:45P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Crescent Cities Center	Riverdale	Prince George

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
247-22-2750	1☐M 2☒F	87 Yrs.			Jan. 18, 1915	Ridge Springs,SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George	Adelphi	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2702 Lackawanna Street	20783	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Seamtress	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Kenner	Metia Holmes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Virginia Brown/Niece	2702 Lackawanna St. Adelphi, MD. 20783

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Jerusalem Church Cem.	June 1, 2002	Ridge Springs, SC.

21. Signature of Funeral Service Licensee ▶ Avay L. Mikell

22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): Chronic Atrial Fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular Disease

Multiple Cardiovascular Accident

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physicien**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M.D	D48213	May 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neelam Ashai, M.D. 4410 74th Ave. Landover Hills, MD. 20784

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 2 4 2002	B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (10)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 13246

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Alice Murphy McNeil	May 15, 2002	4:30 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Southern Maryland Hospital	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
238-50-7417	1☐M 2☒F	68 Yrs.			October 13, 1933	North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	Clinton	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10606 Mullikin Drive	20735	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		Statistical Assistant	U.S.Postal Services

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred Murphy	Agnes Murphy

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Beverly Antionette McNeil (daughter)	10606 Mullikin Drive; Clinton, Maryland 20735

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Maryland National Memorial Park	May 21,2002	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrest	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary arterty disease	
	Due to (or as a consequence of):	
	c. Diabetis	
	Due to (or as a consequence of):	
	d. Cardiomyopathy	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF + HTN.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M. Yemane MD	D0054082	5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mengistu Yemane, M.D.
6104 Old branch Ave. Temple hill, MD 20748

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5-15-02 @ 1630

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

McNeil Mary signed

CR (3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18247

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
RUTH C. MARTIN	MAY 16, 2002	12:28 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOLY CROSS HOSPITAL	SILVER SPRING	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-26-8549	1☐M 2☒F	81 Yrs.			12-31-20	S. C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGE	RIVERDALE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6221 FERNWOOD TERRACE #T-1	20737	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE		WAITRESS	ARCHITECT OF THE CAPITO

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN R. CAROTHERS	LILLIE MAE McCAW

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MICHAEL MARTIN--SON	6221 FERNWOOD TER. #T-1 RIVERDALE, MD 20737

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	HARMONY MEMO. PARK	5/25/02	LANDOVER, MD

21. Signature of Funeral Service Licensee: Theodore C. Pinckney

22. Name and Address of Facility: PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., D. C. 20002

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY FAILURE	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PNEMONIA	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0054566	MAY 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUNITHA BHEGAILEI 8609 - 2ND AVE. SUITE 404B SILVER SPRING, MD 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	Barbara B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Malcolm Crisler McCormack
2. Date of Death (Month, Day, Year): May 17, 2002
3. Time of Death: 7:43 A M
4a. Facility Name (If not institution, give street and number): Doctor's Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 577-40-8929
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 25, 1927
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: College Park
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9348 Cherry Hill Road, #816
10f. Zip Code: 20740
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Edward J. McCormack
18. Mother's Name (First, Middle, Maiden Surname): Josephine Crisler

19a. Informant's Name/Relationship (Type, Print): Miles McCormack/Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 2881, Grand Junction, Colorado, 81502

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory
Date: 5-19-2002
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fort Lincoln Funeral Home, 3401 Bladensburg Road, Brentwood, MD 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sudden Cardiac Death Secondary — 5 Mins.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. To Ventricular Fibrillation — 5 Mins.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D24093
29d. Date signed (Month, Day, Year): May 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Parkhurst, M.D. 7500 Hanover Parkway, Greenbelt, Maryland 20770

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, it is Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 | 8249

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT E. MAYS

2. Date of Death: Month MAY Day 18, Year 2002

3. Time of Death: 10:00 p.m.

4a Facility Name (If not institution, give street and number): 1022 Booker Drive

4b. City, Town, or Location of Death: Capital Heights

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 255-22-1058

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 16, 1917

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Capital Heights

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1022 Booker Drive

10f. Zip Code: 20785

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): William Mays

18. Mother's Name (First, Middle, Maiden Surname): Sarah Young

19a. Informant's Name/Relationship (Type, Print): Patricia Washington (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1022 Booker Drive Capital Heights, Md. 20785

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 05-25-02

20c. Location - City or Town, State: Brentwood, Md.

21. Signature of Funeral Service Licensee: ▶ Wanda C. Bacon CC0361

22. Name and Address of Facility: W. H. Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D.C. 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

b. Renal failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D0045881

29d. Date signed (Month, Day, Year): 5/21/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CARL JOHNSON MD 1221 MERCANTILE LANE LARGO MD 20774

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18250

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mildred May Maharg	May 17, 2002	9:27 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert County Nursing Center	Prince Frederick	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-20-0676	1 ☐ M 2 ☒ F	93 Yrs.			July 12, 1908	Berwyn, MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Lothian	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
313 Ella Drive	20711	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Housewife	Homemaker

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Harvey Rhine	Alice Francis Ward

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alton Maharg (HUSBAND)	313 Ella Drive, Lothian , Maryland 20711-9547

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Lee Crematory	May 19, 2002	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Vascular Accident	3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D 40370	5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter L. Wisniewski, M.D. 10331 Southern Maryland Blvd. #101 Dunkirk, Md.20754

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 2 2 2002	[signature]

CR 20

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18251

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Joseph	McHocko, Jr.	May 21, 2002	02:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Fairland Nursing Home	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
194-16-5808	1 [X] M 2 [ ] F	84 Yrs.			June4,1917	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Adelphi	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10402 Iris Place	20783	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Butcher	Safeway

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph McHocko	Lillian Anthony

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paul A. McHocko - son	10402 Iris Place Adelphi, Maryland 20783

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metropolitan Crematory	5/22/2002	Alexandria, Virginia

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Donald V. Borgwardt	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. cardio pulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. respiratory failure

Due to (or as a consequence of):

c. metastatic melonoma

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

cardiovascular disease

hypertension

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0056147	5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nasreen Kango, M.D. 7610 Carroll Avenue, #205 Takoma Park, Maryland 20912

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	Sandra B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (24)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TALMADGE L MOORE
2. Date of Death: Month 5 Day 13 Year 2002
3. Time of Death: 1:27 AM
4a. Facility Name (If not institution, give street and number): Heartland Nursing Home
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-16-9882
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 1, 1920
9. Birthplace (State or Foreign Country): Great Falls, S.C

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1512 Newton St. N.E.
10f. Zip Code: 20017
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) | College (1-4or 5+): 6yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Counselor
16b. Kind of Business/Industry: DC Public Schools

17. Father's Name (First, Middle, Last): Benjamin Moore
18. Mother's Name (First, Middle, Maiden Surname): Juanita Massey

19a. Informant's Name/Relationship (Type, Print): Carliss MOore/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1512 Newton St. NE Washington, DC 20017

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.
Date: 6-11-02
20c. Location - City or Town, State: Arlington, VA.

21. Signature of Funeral Service Licensee: J. P. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th st.N.W. Washington, D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): e. CARDIO RESPIRATORY FAILURE

Due to (or as a consequence of): b. Hypertension

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of): c. Carcinoma of Prostate

Due to (or as a consequence of): d. Stroke (CVA)

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner es steted. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D42019
29d. Date signed (Month, Day, Year): 05-15-02

30. Name end address of person with completed cause of deeth (Item 23e) (Type, Print): IMRAN CHOWDHURY SUITE 200 / 10724 LITTLE P. PARKWAY COLUMBIA MD 21044

State Registrar

31. Dete filed (Month, Day, Yeer): MAY 22 2002
32. Registrers Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by tha funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CF 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Richard	D.	May Sr.	May 16, 2002	06:10 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
235-52-5215	1 [X] M 2 [ ] F	69 Yrs.			Aug 2, 1932	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	Fort Ashby	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Route 2 Box 130	26719	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-54	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Engineer	Railroad

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Leslie May	Clara (Weaver)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara May wife	Route 2 Box 130; Fort Ashby WV 26719

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Fort Ashby Cemetery	5/20/ 2002	Fort Ashby, WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Carcinoma of the Bladder	2yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Paul T. Livengood MD	D23774	May 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL T. LIVENGOOD MD 912 SETON DR CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	Bonnie G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18254

Miller, Emma C

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EMMA CAROLINE MILLER
2. Date of Death Month/Day/Year: 05 / 16 / 2002
3. Time of Death: 1750
4a. Facility Name (If not institution, give street and number): LIONS MANOR NURSING HOME
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-05-7021
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 28, 1921
9. Birthplace (State or Foreign Country): WEST VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: WV
10b. County: MINERAL
10c. City, Town or Location: RIDGELEY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4 JOHN STREET
10f. Zip Code: 26753
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: HOME
17. Father's Name (First, Middle, Last): LELAND KESSEL
18. Mother's Name (First, Middle, Maiden Surname): MARY CALHOUN
19a. Informant's Name/Relationship (Type, Print): RETHA COWGILL /DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 BLOCKER STREET - RIDGELEY, WV 26753
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): RESTLAWN MEMORIAL GARDENS
Date: 05/20/2002
20c. Location - City or Town, State: LAVALE, MD
21. Signature of Funeral Service Licensee: Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET - CUMBERLAND, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — 10 years
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Cerebrovascular Accident
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D-33280
29d. Date signed (Month, Day, Year): May 20, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Sunil K. Gupta 625 Kent Avenue Cumberland, Maryland 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: Lorna G Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Yes

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2002 18255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Ferguson Mitchell Sr.
2. Date of Death (Month Day Year): May 22 2002
3. Time of Death: 12:15AM
4a. Facility Name (If not institution, give street and number): 308 Maryland Ave
4b. City, Town, or Location of Death: Westernport
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 286-40-5056
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 11 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Allegany
10c. City, Town or Location: Westernport
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 308 Maryland Ave
10f. Zip Code: 21562
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Power Plant

17. Father's Name (First, Middle, Last): Robert F. Mitchell
18. Mother's Name (First, Middle, Maiden Surname): Doris Boal

19a. Informant's Name/Relationship (Type, Print): Katherine Mitchell/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 Maryland Ave, Westernport,Md 21562

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cumberland Crematory
Date: 5/22/02
20c. Location - City or Town, State: Cumberland,Md

21. Signature of Funeral Service Licensee: ▶ F. Wayne Boal
22. Name and Address of Facility: Boal Funeral Home,111 Church Street Westernport,Md 21562

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic metastases - adenocarcinoma — 9mo.
Due to (or as a consequence of):
b. Unknown Primary — One year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Adenocarcinoma lung, Melanoma skin
Atherosclerotic coronary artery disease
Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Thomas Devlin MD
29c. License number: D 21488
29d. Date signed (Month, Day, Year): May 22, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Thomas Devlin, 20 Douglas Ave, Lonaconing, Md 21539

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: ▶ Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18256

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
Edgar	Bruce	Morrison Jr.	May 24, 2002	08:41pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1725 Frederick Street	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
705-10-5364	X 1 M 2 F	90 Yrs.			Mar 7, 1912	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1725 Frederick Street	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married XX Widowed 4 Divorced	X 1 Yes 2 No If Yes, Give Year or Dates: WWII	1 Yes X 2 No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Yardmaster	Railroad

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edgar Bruce Morrison, Sr.	Sara R Willhide

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert C. DeMoss friend	11301 DeHaven Rd, NE;Cumberland,MD21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Rocky Gap Veterans Cem	5/28/	2002 Flintstone, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J Scarpelli	Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No X 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes X 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
X 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home X 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
X 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. X 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Paul Snow MD	D09157	May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
MAY 28 2002	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18257

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Harry Bernard Marshall	May 24 2002	1433 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-09-6507	1☒M 2☐F	91 Yrs.			Jan. 5, 1911	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Williamsport	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16505 Virginia Avenue Cottage 45	21795	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Owner/Operator	Plumbing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert Moses Marshall	Mary Emma

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia M. Marshall-Wife	16505 Virginia Ave. Cottage 45 Williamsport, Maryland 21795

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Haven Cemetery	May 29, 2002	Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Craig M. Osborne

22. Name and Address of Facility: Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 21795

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 2 Hours.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Coronary Artery Disease
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes; Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Eli Rozn MD	D 22313	5-25-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Eli Rozn MD Washington County Hospital

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	Deputy G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARTHUR HOWELL MYERS

2. Date of Death (Month, Day, Year): may 23 2002

3. Time of Death: 5:30 PM

4e. Facility Name (If not institution, give street and number): 18430 MT. LOCK HILL ROAD

4b. City, Town, or Location of Death: SHARPSBURG

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 215-14-2885

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): DEC. 30, 1922

9. Birthplace (State or Foreign Country): MARYLAND

Usuel Residence ot Decedent

10a. Stete: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: SHARPSBURG

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 18430 MT. LOCK HILL ROAD

10f. Zip Code: 21782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER

16b. Kind of Business/Industry: HOME CONSTRUCTION

17. Father's Name (First, Middle, Last): CHARLES AARON MYERS

18. Mother's Name (First, Middle, Maiden Surname): BLANCHE CORA CRAMPTON

19a. Informant's Name/Reletionship (Type, Print): SHIRLEY MYERS/SISTER-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 18430 MT. LOCK HILL ROAD, SHARPSBURG, MD 21782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SAMPLES MANOR CEMETERY

Date: 5/28/02

20c. Location - City or Town, State: SHARPSBURG, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name end Address of Facility: BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

e. laryngeal Cancer — 8 months

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: Hind Hamdan MD

29c. License number: D46473

29d. Date signed (Month, Dey, Year): 5/28/02.

30. Neme end address ot person who completed cause of deeth (Item 23e) (Type, Print): Hind Hamdan, MD; 1130 OPAL CT; Hagerstown, MD 21740

State Registrar

31. Dete filed (Month, Dey, Year): MAY 29 2002

32. Registrer's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
FLORENCE ELIZABETH MOORE	MAY 13, 2002	10:53 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6602 Walston Switch Road	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-16-6013	1☐ M 2☒ F	77 Yrs.			March 21,1925	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6602 Walston Switch Road	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	-	Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George W. Welch	Mary Aliene Murphy

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Irene e. Moore/Daughter	6602 Walston Switch Rd., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Wicomico Memorial Park	5/16/02	Salisbury, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Advanced Parkinson's Ds.	> 20yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of the Breast
Sacral Decubitus Ulcer
CHF, Renal Insufficiency, UTI

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D24986	5/16/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert J. Reilly MD 560 Riverside Dr B101 Salisbury md 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARNETTA DENISE MANN
2. Date of Death Month Day Year: 5 - 12 - 02
3. Time of Death: 1000 M
4a. Facility Name (If not institution, give street and number): 702 - BOOTH ST
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-66-0010
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 47 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-16-55
9. Birthplace (State or Foreign Country): MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 702 - BOOTH ST
10f. Zip Code: 21801
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: IMS

17. Father's Name (First, Middle, Last): AUBREY MANN
18. Mother's Name (First, Middle, Maiden Surname): ETHEL CHURCH MANN

19a. Informant's Name, Relationship (Type, Print): AARON MANN - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1301-MARKET ST. DENTON MD. 21629

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN ACRES
Date: 5/17/02
20c. Location - City or Town, State: SALISBURY MD.

21. Signature of Funeral Service Licensee: Russell Fox
22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY MD.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive heart disease — 2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. DM
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Obesity

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD DFME
29c. License number: H50497
29d. Date signed (Month, Day, Year): 5/16/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRIS SNYDER DMC 100 E CARROLL ST. SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 16 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
RAY DAVID MORRIS, JR	MAY 18, 2002	10:40 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SR HARFORD MEM. HOSPITAL	HOEG	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-22-6567	1☒M 2☐F	75 Yrs.			July 27, 1926	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Havre de Grace	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
505 Congress Ave. Apt.409	21078	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: Korea	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9	0	Assembly line worker	Shoe Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ray D. Morris, Sr.	Beulah Mae Moulsdale

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Grace L. Ely (Sister)	800 Cedar Lane Bel Air, Maryland 21015

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Harford Memorial Gardens	5/21/02	Aberdeen, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kirsten Ann Engleskes	Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HASCVD	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

S/P PROSTATIC CARCINOMA.
VALVULAR HEART DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] DME	OCME	MAY 18 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GS PRABHU MD 2336 YORK RD TIMONIUM MD 21093.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7/27/26

MORRIS, RAY D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
ROZALIA	MOLDRZYK	May 18 2002	4:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1 N. Luzerne Avenue	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
042-26-6098	1 ☐ M 2 ☒ F	86 Yrs.			November 3, 1915	Poland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1 N. Luzerne Avenue	21224	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Falk	Rozalia Sekowski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eugeniusz S. Moldrzyk/Son	5313 Wright Avenue, Baltimore, Md. 21205

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Parapia SW.M. Magdaleny	5-24-2002	Czersk, Poland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21205

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 5 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] PHYSICIAN	D53590	MAY 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDNEY DY, MD ROOM 8033 1830 EAST MONUMENT BALTIMORE MD 21205

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#23a Per Phy 5/22/2002 **Certificate of Death** HCHD LM Reg. No. 2002 18263

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Eugenia Davis Macintire
2. Date of Death Month Day Year: May 16, 2002
3. Time of Death: 2:10 AM M
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-03-7642
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 23, 1916
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 310 Fords Lane
10f. Zip Code: 21001
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles (nmn) Davis
18. Mother's Name (First, Middle, Maiden Surname): Annabelle (nmn) Sloan

19a. Informant's Name/Relationship (Type, Print): Gould O. Macintire- Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 Fords Lane, Aberdeen, Maryland 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. George's Episcopal Date: 5-18-02
20c. Location - City or Town, State: Perryman, Maryland

21. Signature of Funeral Service Licensee: Charles A. Emge
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. INANITION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. END STAGE ASCVD
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D43725
29d. Date signed (Month, Day, Year): 5/16/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

FRANCES MACINTIRE
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036
MAY 16, 2002 2:10 a.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18264

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Diehl Neat

2. Date of Death Month Day Year: May 25, 2002

3. Time of Death: 04:00 AM M

4a. Facility Name (If not institution, give street and number): Frostburg Village Nursing Care Center

4b. City, Town, or Location of Death: Frostburg

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 185-12-7080

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04-Dec-10

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Pennsylvania

10b. County: Allegheny

10c. City, Town or Location: Pittsburgh

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 30 Clarion Avenue

10f. Zip Code: 15202-

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): sales person

16b. Kind of Business/Industry: retail store

17. Father's Name (First, Middle, Last): Gustave Kramer

18. Mother's Name (First, Middle, Maiden Surname): Anna Storch

19a. Informant's Name/Relationship (Type, Print): Sandra Mudd granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1103 Davis Avenue Pittsburgh Pennsylvania 15212-

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Christ Our Redeemer Cemetery

Date: 28-May-02

20c. Location - City or Town, State: Pittsburgh, Pennsylvania

21. Signature of Funeral Service Licensee: John R. Durst

22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Cerebro Vascular accident — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive Cerebro Vascular Disease — 50 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia Psychosis - Osteoporosis

Hx Sepsis and aspiration Pneumonia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S C Sandhir MD

29c. License number: D14464

29d. Date signed (Month, Day, Year): 5/29/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. L. Sandhir, M.D., 48 Tam Terrace, Frostburg, Maryland 21532

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#19A PER INFMNT. G808 6-19-02 JAB

Certificate of Death

Reg. No. 2002 18265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elva B. O'Connor
2. Date of Death (Month, Day, Year): May 23 2002
3. Time of Death: 11:20 A.M.

4a. Facility Name (If not institution, give street and number): Homewood Nursing Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 579-88-4742
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 17 1912
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7407 Willow Road
10f. Zip Code: 21702
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- | College (1-4or 5+): -2-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Department of Agriculture

17. Father's Name (First, Middle, Last): William D Baynum
18. Mother's Name (First, Middle, Maiden Surname): Henrietta Littleton

19a. Informant's Name/Relationship (Type, Print): ~~Jeremiah~~ JERIE P. O'Connor Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 312 Silver Crest Dr. Walkersville,MD 21793

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery
Date: May 25 2002
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ Robert E. Evans
22. Name and Address of Facility: Evans Funeral Home, INC. 16000 Annapolis Rd. Bowie, MD 20715

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

D.O.D 5/23/02 T.O.D. 11:20am

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Lerner MD
29c. License number: D41619
29d. Date signed (Month, Day, Year): May 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Lerner 63 Thomas Johnson Drive, Frederick MD 21702

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Known to physicians as: Elva B. O'Connor

CR (10)

State Registrar

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar MEND ITEM#18,19a&19b PER F.H. G806 7-22-02 JAB Amend#23aPrt.1PerPhys.PGC 5-24-02cr

Certificate of Death

Reg. No. 2002 18266

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Michele Dawn Parker	May	17	2002	12:24 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Geriatric Center	Baltimore City	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-82-3691	1☐M 2☒F	38 Yrs.			Feb. 8, 1964	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Hyattsville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2026 Powhatan Road	20782	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Customer Service	Private Business

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Reginald Tate	IRMA ANGELA CRESSOTTI ~~Jean Anne Cressotti~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JEAN ANN TATE / SISTER ~~Jean Anne Ager - Mother~~	53 GLENRIDGE ROAD #B-1 GLEN BURNIE, MD 21061 ~~2627 Powhatan Woods Hyattsville, MD 20782~~

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	05/18/2002	Alexandria, VA

21. Signature of Funeral Service Licensee: Robert L. May

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	48 hours
Due to (or as a consequence of):	b. Pressure Wounds	6 months
Due to (or as a consequence of):	c. Multiple Sclerosis	
Due to (or as a consequence of):	d.	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MS Dementia
Depression
Malnutrition

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0052243	May 21, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Blumenthal, M.D., 5505 Hopkins Bayview Circle, Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Jennifer B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

CR (4)

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Steven Keith Poulin
02-2568-017
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18267

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Steven Keith Poulin	May	17	2002	11:23 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Wilson Road and Rock Point Road	Issue	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
506 11 5039	1☒M 2☐F	19 Yrs.					Sept 18, 1982	Nebraska

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Fort Washington	1☐Yes 2☒No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2000 Palmer Road	20744	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☐No If Yes, Give Year or Dates: XX	1☐Yes 2☒No XX Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Mechanic	Wal-Mart

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Stephen Poulin	Catherine Schrader

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Stephen Poulin (FATHER)	2000 Palmer Road, Fort Washington, Maryland 20744

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lee Crematory	May 23, 2002	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven G. Smith	Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☒Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	05-17-2002	11:05 P M	1☐Yes 2☐No	passenger in auto - auto in collision with tree

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Roadway	Wilson Road and Rock Point Road, Issue, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	May 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	Barbara G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (10)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#8.Per FH PGC 5/29/02 cr

Certificate of Death

Reg. No. 2002 18268

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ida Jane Pupjak

2. Date of Death: Month May Day 19, Year 2002

3. Time of Death: 10:25A. M

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-24-1184

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June ~~6,~~ 5, 1925

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4411 Romlon Street, #202

10f. Zip Code: 20705

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Ira Joseph Toleman

18. Mother's Name (First, Middle, Maiden Surname): Blanche Tolley

19a. Informant's Name/Relationship (Type, Print): John G. Pupjak - husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4411 Romlon St., #202 Beltsville, Maryland 20705

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Union Cemetery

Date: 5/23/2002

20c. Location - City or Town, State: Burtonsville, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bilateral Pneumonia — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

cerebrovascular accident; chronic atrial fibrillation; congestive heart failure

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D24721

29d. Date signed (Month, Day, Year): May 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Syed Sadiq, M.D. 14333 Laurel Bowie Road, #208 Laurel, Maryland 20708

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#5 PER F.H. 7-2-02 JAB G809

Certificate of Death

Reg. No. 2002 18269

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Harlan E. Porter	May 16, 2002	02:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
~~195-30-7389~~ 212-54-8450	1☒M 2☐F	93 Yrs.			Sept. 27, 1908	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
PA	Bedford	Buffalo Mills	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6723 Hyndman Road	15534	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Armed Forces/US Army	US Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Ross Porter	Nellie Waltman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joe Porter/son	37 John Dyer Way, Doylestown, PA 18901

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Porter Cemetery	May 18, 2002	Hyndman, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert C. Adams	Harvey H. Zeigler FH, Hyndman, PA 15545

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Madical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D54765	May 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robert E. Rapp 912 Seton Dr., Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Yeer)	32. Registrar's Signature
MAY 20 2002	[signature] G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18270

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	Time of Death
Eugene Paxton, Jr.	MAY 17,2002	17:29pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
233-68-1354	1 X M 2 ☐ F	59 Yrs.			Nov 25, 1942	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	Keyser	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1290 Lynmar Street	26726	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Outside Roll Svc Coordinator	Mead-Westvaco

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Eugene W. Paxton, Sr.	M. Leota Williams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Carolyn Paxton--wife	1290 Lynmar Street; Keyser, WV 26726

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Potomac Mem Gardens	5/21/2002	Keyser, WV

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wm H Dunlop Sr	Fredlock Funeral Home 31 Jones St; Piedmont, WV 26750

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. End Stage Adenocarcinoma of Ampulla	One year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gary Wagoner MD	D 22181	MAY 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary Wagoner, M.D. 935 Bishop Walsh Road Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar: Item#1 & Amend Item#23a Per Phy 5/22/2002

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

HCHD LM

Reg. No. 2002 18271

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Nancy C. Pelissier~~ Nancy Carolyn Pelisser

2. Date of Death: Month 05 Day 13 Year 2002

3. Time of Death: 15:25 ~~PM~~

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: ---------

Funeral Director

5. Social Security Number: 240-60-4638

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 17, 1936

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 503 Joppa Farm Road

10f. Zip Code: 21085

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Radiotechnologist

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Hal C. Boger

18. Mother's Name (First, Middle, Maiden Surname): Charlotte Louise Miller

19a. Informant's Name/Relationship (Type, Print): Normand A. Pelissier/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 503 Joppa Farm Road, Joppa, MD 21085

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. George's Cem.

Date: 5/16/02

20c. Location - City or Town, State: Perryman, Maryland

21. Signature of Funeral Service Licensee: Holly McComas PA

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Systemic Inflammatory Response Syndrome / Sepsis

Due to (or as a consequence of):

b. ~~lower extremity ischemia~~ Sepsis — ~~10 days~~

Due to (or as a consequence of):

c. ~~myocardial infarction~~ lower extremity ischemia — ~~9 days~~

Due to (or as a consequence of):

d. ~~metastatic carcinoma~~ myocardial infartion — ~~unknown~~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

congulopathy

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Cynthia J. Bucci MD

29c. License number: P14147

29d. Date signed (Month, Day, Year): 05-13-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia J. Bucci MD UMMS (University Hospital) Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: Denise B Sparks

14

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18272

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Violet Reid	May 17, 2002	6:15a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Heartland of Hyattsville	Hyattsville	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
223-12-1364	1☐ M 2☒ F	84 Yrs.			Sept. 14, 1917	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.		Washington	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2210 Otis Street, NE	20018	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Waitress	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unobtainable	Unobtainable

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dennis Shriver/Friend	4900 Monroe St., Bladensburg, MD 20710

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Fort Lincoln Cemetery	5-24-2002	Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Fort Lincoln Funeral Home, 3401 Bladensburg Rd., Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest — 5/2002

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Congestive Heart Failure

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Jocelyn N. El-Sayed	D56414	5/22/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Jocelyn N. El-Sayed, MD, MPH 6500 Riggs Rd. Hyattsville, MD 20783

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CR 8

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18273

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Harvey Franklin Richardson, Sr.	May 21, 2002	10:00 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6388 Glenmore Avenue	Elkridge	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-26-9643	1[X] M 2[ ] F	88 Yrs.			April 1, 1913	Washington,D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Elkridge	[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6388 Glenmore Avenue	21075	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ] Never Married 2[ ] Married 3[ ] Widowed 4[X] Divorced	1[X] Yes 2[ ] No If Yes, Give Year or Dates: WWII	1[ ] Yes 2[X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Machinist/Welder	U.S. Navy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Vincent Richardson	Agnes Thompson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joseph Richardson - Son	8806 Rhode Island Avenue, College Park, Maryland 20740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other (Specify)	Fort Lincoln Cemetery	May 25, 2002	Brentwood,Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Henry L. Gasch	Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville,Maryland 20781

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's dementia, end stage	4 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1[ ] Yes 2[ ] No 9[ ] Unknown

23c. If yes, outcome of pregnancy 1[ ] Live birth 2[ ] Fetal death 3[ ] Ectopic pregnancy 4[ ] Pregnant at time of death 5[ ] Other (specify) _____ 9[ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

Sacral Decubitus Ulcer

23e. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No

26. Place of Death (Check only one)
Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA
Other: 4[ ] Nursing Home [X] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1[X] Natural 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1[ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2[ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Marshal Bennett MD	D0052761	5/22/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Martha Bennett, M.D.,12201 Plum Orchard Drive, Silver Spring, Maryland 20904

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Barbara B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 8/11a

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOHNNIE J. RUSH	May 16, 2002	11:35 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St.Thomas More NUrsing Home	Hyattsville	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
248-10-0008	1☒M 2☐F	85 Yrs.			June 16,1916	Olanta,S.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Laurel	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9512 Muirkirk Road #101	20708	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Electrian	Gov. GSA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Rush	Mary Estelle

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara R.Purnell-Daughter	1904 Winter Green Ave.District Hgts,Md.20747

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Md.Nat'l Mem.Park	May 23,2002	Laurel,Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Francis B. Hunt	Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Malignancy	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypoalbuminaemia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D19609	5-18-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Raman R.Tuli,M.D. 3503 Perry St.Mt.Rainier,Md.20712

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (5)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Robert E. Rodgers	May 18 2002	4 22 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
417-60-3885	1 ☒ M 2 ☐ F	80 Yrs.			May 29, 1921	Alabama

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Hyattsville	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5721 43rd Avenue #2	20781	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-8-	-0-	Farmer	Farming Business

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Fred J. Rodgers	Mary Motes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Brenda Fisher Neice	1793 Cameron Court Crofton, MD 21114

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Huntt Crematory	05-22-2002	Waldorf, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert E Evans	16000 Annapolis Road Evans Funeral Home Bowie, Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE PULMONARY EDEMA	3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. SEPTICEMIA Due to (or as a consequence of):	2 Weeks
	c. RENAL FAILURE Due to (or as a consequence of):	1 month
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CITRUS CURE NIGRAE
MRSA CELLULITIS

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D14220	5-18-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neil A Meade 4811 Mallard Drive Laurel MD 20708

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Rodgers, Robert

CR (4)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marguerite W. Richards
2. Date of Death: Month May Day 16 Year 2002
3. Time of Death: 11:10 A.M.

4a. Facility Name (If not institution, give street and number): Spa Creek Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel County

Funeral Director

5. Social Security Number: 014-14-3447
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 24 1912
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Gambrills
10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1712 Basil Way
10f. Zip Code: 21054
10g. Citizen of What Country? United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- College (1-4or 5+): -4-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerical Work
16b. Kind of Business/Industry: Government Accounting Office - U.S. Government

17. Father's Name (First, Middle, Last): William Pell Welshans
18. Mother's Name (First, Middle, Maiden Surname): Eva Mae Rockey

19a. Informant's Name/Relationship (Type, Print): Al Richards Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1712 Basil Way Gambrills, MD 21054

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Huntt Crematory
Date: May 21, 2002
20c. Location - City or Town, State: Waldorf, Maryland

21. Signature of Funeral Service Licensee: Robert E Evans
22. Name and Address of Facility: Evans Funeral Home, Inc. 16000 Annapolis Road Bowie, Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. ISCHEMIC CARDIOMYOPATHY
Approximate Interval Between Onset and Death: 2 YRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Brian C Wallace MD
29c. License number: D31136
29d. Date signed (Month, Day, Year): MAY 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN C. WALLACE MD 35 MILKSHAKE LN. ANNAPOLIS, MD 21403

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002
32. Registrar's Signature: Barbara B. Sparks

CR (10)

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
ELIAS	REDD	MAY 15 2002	4:32 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2504 Eliot Place	Temple Hills	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
430-30-5761	1 [X] M 2 [ ] F	79 Yrs.			July 12, 1922	Helena, Arkansas

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Temple Hills	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2504 Eliot Place	20748	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	3	National Security Officer	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willie Redd	Ada Johnson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Redd/ Wife	2504 Eliot Place Temple Hills, MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Maryland Veterans Cem.	May 24	Cheltenham, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Kimberly C Bruce Tonic	MARSHALL'S Funeral Home of MD 4308 Suitland Road Suitland,MD 20746

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC CARCINOMA LUNG	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Athritis

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Moti Koal	D24026	May 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moti Koal, M.D. 4467 Old Branch Ave. #203 Temple HIlls, MD 20748

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Geneva B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 10/16

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18278

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Edward	Allen	Ritchie	May 16, 2002	08:00pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
12015 Siebert Road SE	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-18-1024	1 X M 2 F	81 Yrs.			May 25, 1920	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1 Yes X 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12015 Siebert Road SE	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married X 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Textile

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank Ritchie	Ina (Dove)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Larry Ritchie son	12515 Limestone Rd SE;Cumberland,MD21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Davis Memorial Cemeter	5/20/	2002 Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Nicholas J. Scarpelli	Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Heart Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown	
24a. Was an autopsy performed? 1 Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Paul Snow, MD	D09157	May 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18279

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Freda Mae Rice	MAY 20, 2002	11:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-14-6321	1☐M 2☒F	82 Yrs.			April 16 1920	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Allegany	Lonaconing	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
16002 St. Marys Terrace	21539	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown		Homemaker	Housework

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Price Green	Jesse Beeman

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Jane Shircliff/ daughter	12819 McKay Ave., Cresaptown, Maryland 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Rest Lawn Mem. Garden	05/24/ 2002	LaVale, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ F. Wayne Boal	Boal Funeral Home 111 Church St., Westernport, Md. 21562

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	About 5 YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CORONARY ARTERY DISEASE	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE
DIABETES MELLITUS
ATRIAL FIBRILLATIONS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ H Sidhu	D26907	MAY 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Harjit Sidhu M.D. 925 Bishop Walsh Road Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	▶ G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
James E. Ruppenkamp	May 18, 2002	04:30am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
729 Oldtown Road	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-30-1637	1☒M 2☐F	68 Yrs.			Jan 29, 1934	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	X 1☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
729 Oldtown Road	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married X 3☐Widowed 4☐Divorced	1☒Yes 2☐No X If Yes, Give Year or Dates: Korea	1☐Yes 2☒No X Specify:	Specify White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Box Shop	P.P.G.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John George Ruppenkamp	Clara (O'Neal)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Ruppenkamp wife	729 Oldtown Road; Cumberland, MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial X 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Mary's Cemetery	5/21/ 2002	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Nicholas J. Scarpelli	Scarpelli Funeral Home P.A. Cumberland, Maryland 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Mesothelioma — 13 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0023371	05-23-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Qamar Zaman, M.D.; 625 Kent Avenue; Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2002 18281

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Russell Leroy Rhinehart
2. Date of Death Month Day Year: May 27, 2002
3. Time of Death: 9:25 A.M.
4a. Facility Name (If not institution, give street and number): 17509 Va. Ave.
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-32-4153
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 16, 1935
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 17509 Va. Ave.
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Deliver
16b. Kind of Business/Industry: Pharmacy

17. Father's Name (First, Middle, Last): David P. Rhinehart
18. Mother's Name (First, Middle, Maiden Surname): Glendora Long

19a. Informant's Name/Reletionship (Type, Print): Carolyn E. Rhinehart (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17509 Va. Ave. Hagerstown, Md. 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Lawn Memorial Park
Date: May 29, 2002
20c. Location - City or Town, State: Hagerstown, Md.

21. Signeture of Funeral Service Licensee: Dennis L. Davis
22. Name and Address of Facility: Davis Funeral Home, 12525 Bradbury Ave. Smithsburg, Md. 21783

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. lung cancer — 1 year
Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or es e consequence of):
c. Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: Hind Hamdan MD
29c. License number: D46473
29d. Date signed (Month, Dey, Year): 5/28/02

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Hind Hamdan, MD; 1130 OPAL CT.; Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrer's Signature: Geneva G. Spader

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Helen Maye Semerling	May 20, 2002	12:20 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
342-26-8370	1☐M 2☒F	71 Yrs.			Feb. 17, 1931	Ohio

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Virginia	Fairfax	Annandale	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6732 Fern Lane	22003	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	Registered Nurse	Nursing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Henry Rader	Bernice Nelson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ronald F. Semerling / Spouse	6732 Fern Lane, Annandale, VA 22003

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	Spring Grove Cem.	May 30,2002	Cincinnati, Ohio

21. Signature of Funeral Service Licensee: Diana L Lero

22. Name and Address of Facility: Demaine Funeral Home, 5308 Backlick Rd, Springfield, VA 22151

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Uterine Cancer	Months
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Paul MacKoul	D47612	May 22, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul MacKoul, M.D., 8218 Wisconsin Ave, Bethesda, MS 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Sandra B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

CR 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18283

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Bernice L. Smith	MAY 17 2002	11:17A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctors Community Hospital	Lanham	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
228-32-6327	1☐M 2☒F	76 Yrs.			12/11/1925	Moreland Cty, VA West

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Upper Marlboro	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5022 Ashford Dr	20772	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th		Homemaker	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Simon Muse	Thelma Cuttingham

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frenchettia Payne/Granddaughter	5022 Ashford Dr Upper Marlboro, MD 20772

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	History LandMemorial	05-25-2002	King George, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Chester Bivins	JB Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. coronary Artery disease	yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. peripheral vascular disease	yrs
	Due to (or as a consequence of): c. Diabetes	yrs
	Due to (or as a consequence of): d. chronic Renal Insufficiency	yrs

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

peripheral neuropathy

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M.D.	D41978	5-18-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nader Tavakoli 4000 Mitchellville Rd A312 Bowie MD 20716

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification; To Be Completed by Physician/Medical Examiner

SMITH, Bernice

CR (4)

02-2656-033
B.K.S
DONNA SHRODES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 061802:ITEMS#23a,ptII,27 per ME G808 ss

Reg. No. 2002 18284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Donna Jean Shrodes	MAY 23, 2002	0012 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES HOSPITAL CENTER	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
175-62-2524	1☐M 2☒F XX	28 Yrs.			Feb. 05, 1974	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Bowie	XX 1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2100 Ardleigh Court	20716	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No XX Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-	-5-	Software Programer	Computer Science

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Delbert Shrodes	Lydia A. Stevenson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Delbert Shrodes Father	2100 Ardleigh Court Bowie, Maryland 20716

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Huntt Crematory	05-24-2002	Waldorf, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Rena Aldridge	Evans Funeral Home, Inc. 16000 Annapolis Road Bowie, Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. REACTIVE AIRWAY DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☒Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

FATTY LIVER

HYPERTENSEIVE CARDIOVASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E	MAY 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPPLE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Bernice B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18285

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George S. Sunday, Sr.
2. Dete of Deeth — Month: May Day: 18 Year: 2002
3. Time of Death: 11:10 pm
4a Facility Name *(If not institution, give street end number)*: 10916 Montgomery Road
4b. City, Town, or Location of Deeth: Beltsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-12-1822
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr. 11, 1921
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usuet Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 10916 Montgomery Road
10f. Zip Code: 20705
10g. Citizen of What Country?: U.S.A.

11. Maritat Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American tndian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: District Manager
16b. Kind of Business/Industry: C&P Telephone Co.

17. Father's Neme *(First, Middle, Last)*: George Otto Sunday
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Stevens

19a. Informant's Name/Relationship *(Type, Print)*: George S. Sunday, Jr. - Son
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 8202 Honeysuckle Drive, Liverpool, NY 13090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veterans Cemetery
Date: 05/22/02
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service licensee: Henry S. Ford
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Prostate Cancer — 8 Years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part t.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of tnjury M
28c. tnjury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D35635
29d. Date signed *(Month, Day, Year)*: May 20, 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Joseph Kaplan, M.D., 9715 Medical Center Dr., Ste. 221, Rockville, MD 20850

State Registrar

31. Dete filed *(Month, Day, Yeer)*: MAY 2 0 2002
32. Registrer's Signature: Barbara D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR 15/16

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#25.PerME/PGC 5-20-02 cr

Certificate of Death

Reg. No. 2002 18286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Joseph Vincent Santilli	MAY 7, 2002	5:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Doctor's Community Hospital	Lanham	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-18-7349	1☒M 2☐F	85 Yrs.			May 2, 1917	Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	College Park	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5115 Kenesaw Street	20740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1941-45	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Repairman	Private Industry

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Vincent Santilli	Unavailable

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary J. Santilli - Spouse	5115 Kenesaw Street, College Park, MD 20740

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Fort Lincoln Cemetery	May 13, 2002	Brentwood, Maryland

21. Signature of Funeral Service Licensee: Robert E. May

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia.	1 wk.
Due to (or as a consequence of):	b. Impaired Gag Reflex due to Dementia	> 1 mo.
Due to (or as a consequence of):	c.	
Due to (or as a consequence of):	d.	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease, Hypertension, Congestive Heart Failure, Impaired Glucose Tolerance Dementia, Obstructive Uropathy

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes ~~2☐No~~

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification; To Be Completed by Physician/Medical Examiner

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D31010

29d. Date signed (Month, Day, Year): May 9, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart Turkewitz, MD — 7500 Greenway Ctr. Dr. #430 Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): MAY 2 0 2002

32. Registrar's Signature: Barbara B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

JOSEPH VINCENT SANTILLI

1/Va

CR (4)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18287

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Edward Shorter, Jr.
2. Dete of Deeth Month / Dey / Year: May 10, 2002
3. Time of Deeth: 7:00 A.M.

4a. Feciity Name *(If not institution, give street end number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 577-50-2712
6. Sex: 1[X] M 2[ ] F
7. Age *(In yrs. lest birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: November 2, 1938
9. Birthplace *(State or Foreign Country)*: Washington,D.C.

Usuel Residence of Decedent

10a. Stete: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1[X] Yes 2[ ] No

10e. Street end Number: 402 "O" Street, N. W.; Apt. 303
10f. Zip Code: 20001
10g. Citizen of What Country?: United States

11. Marital Status: 1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1[ ] Yes 2[X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1[ ] Yes 2[X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8th grade; College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Street Maintenance Worker
16b. Kind of Business/Industry: D. C.Public Works Dept. of Sanitation

17. Father's Neme *(First, Middle, Last)*: Joseph Edward Shorter, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy Tate

19a. Informant's Name/Relationship *(Type, Print)*: (Wife) Thomasine Eudora Foreman Shorter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 385 Cumberland Street;Brooklyn, New YOrk 11238

20a. Method of Disposition: 1[X] Burial 2[ ] Cremation 3[ ] Removal from State 4[ ] Donation 5[ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery — Date: May 17,2002
20c. Location - City or Town, State: Washington, D. C.

21. Signeture of Funeral Service Licensee: [signature]
22. Name and Address of Facility: R. N. Horton Company Morticians, Inc. 600 Kennedy Street,N.W.;Washington,D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atrial Fibrillation — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Hypertension — 1 year
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an eutopsy performed? 1[ ] Yes 2[X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1[ ] Yes 2[ ] No

25. Was case referred to medical examiner? 1[ ] Yes 2[X] No

26. Place of Death *(Check only one)*: Hospitel: 1[ ] Inpatient 2[X] ER/Outpatient 3[ ] DOA — Other: 4[ ] Nursing Home 5[ ] Residence 6[ ] Other *(Specify)*

27. Menner of Death: 1[X] Naturel 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigation 6[ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1[ ] Yes 2[ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1[X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2[ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: [signature] Michael R. Dobridge, M.D.
29c. License number: D00 1138
29d. Date signed *(Month, Dey, Year)*: May 17, 2002

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Michael R. Dobridge, M.D., PA — Layhill Center/Genesis ElderCare Network 3227 Bel Pre Road;Silver Spring,Maryland 20906

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 2 0 2002
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CL (3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend#23a.Prt.1.PerPhys.PGC 5-29-02 CT

Certificate of Death

Reg. No. 2002 18288

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
HARRY	SCHAFFER	May	20,	2002	12:50P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
111-22-5435	1☒M 2☐F	80 Yrs.			Sept.10,1921	Poland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2529 Ross Road, #101	20910	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1941-1944	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	Management Analyst	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Simon Schaffer	Gertrude Tabak

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth Schaffer - wife	2529 Ross Road, #101 Silver Spring, Maryland 20910

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Judean Memorial Gardens	5/22/2002	Olney, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald V. Borgewardt	Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
a.	Immediate Cause (Final disease or condition resulting in death): Pneumonia	3wks.
b.	Due to (or as a consequence of): LYMPHOCYTIC Chronic Lymphomatic Leukemia	10yrs.
c.	Due to (or as a consequence of):	
d.	Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Endocarditis
Thrombocytopenia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Peter B. Sherer MD	D 21910	may 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Peter B. Sherer MD 3921 Ferrara Dr Wheaton, MD 20906

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

UR (15)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Amended #196 mls, 5/21/02, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert Gibson Shockey	May 19, 2002	8:30 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
21321 Charlestown Road	Lonaconing	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-03-8007	1☒M 2☐F	81 Yrs.			May 10, 1921	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Allegany	Lonaconing	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
21321 Charlestown Road	21539	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9	0	Barber	Hair

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Edward Shockey	Clara Marie Teasdale

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alice Jean Shockey-Wife	21321 Charlestown Road, Lonaconing, Maryland 21539

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Oak Hill Cemetery	May 23, 2002	Lonaconing, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jim E. McKenzie	Eichhorn-McKenzie Funeral Home P.A., Lonaconing Md 21539

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatocellular Carcinoma — 4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Chronic Obstructive Pulmonary Disease

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D0033280	May 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
625 Kent Ave Suite 101 Cumberland, Md 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	▶ G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

mls

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18290

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA MAY SMITH

2. Date of Death: Month: May; Day: 17; Year: 2002

3. Time of Death: 7:35 a.m.

4a. Facility Name (If not institution, give street and number): Moran Manor Nursing Home

4b. City, Town, or Location of Death: Westernport

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 236-44-6943

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 17, 1930

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Piedmont

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 51 Jones Street, Apt. 409

10f. Zip Code: 26750

10g. Citizen of What Country: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Shoe Factory

17. Father's Name (First, Middle, Last): Oscar Lee Day

18. Mother's Name (First, Middle, Maiden Surname): Nora Virginia Grabiel

19a. Informant's Name/Relationship (Type, Print): Edward K. Smith/ Son

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 51 Jones Street, Apt. 508 Piedmont, WV 26750

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Queen's Point Cemetery

Date: May 21 2002

20c. Location - City or Town, State: Keyser, WV

21. Signature of Funeral Service Licensee: ▶ Brian L Smith

22. Name and Address of Facility: Smith Funeral Home 85 S. Main Street Keyser, WV 26726

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. Carcinoma of cervix with metastasis — 2 years

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease; chronic obstructive pulmonary disease; Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted.

29b. Signature end title of certifier: ▶ Jean

29c. License number: D21244

29d. Date signed (Month, Day, Yeer): May 21, 2002

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Jesus Tan, M.D. Moran Manor Nursing Home Westernport, MD 21562

State Registrar

31. Date filed (Month, Day, Yeer): MAY 22 2002

32. Registrer's Signature: ▶ Brenda G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18291

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MARIAN	J.	SUTTON	May 17 2002	1116 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-52-9994	1☐M 2☒F	54 Yrs.			JAN. 8, 1948	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WICOMICO	SALISBURY	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
907 OUTTEN RD.	21804	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM PERLMAN	REBECCA LEVIN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CHARLES A. SUTTON - HUSBAND	907 OUTTEN RD. SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BETH ISRAEL CEMETERY	5/22/2002	SALISBURY, MARYLAND

21. Signature of Funeral Service License	22. Name and Address of Facility
▶ B. Keith Lippy, CFSP	BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. 21804 SALISBURY, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Gallbladder

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death Check only one
Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D29105	5/20/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christian Huddleston, MD 106 Milford Street Salisbury, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	▶ Jeanne G Sparks

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural', or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

MARIAN SUTTON 216-52-9994

5DQ

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
ANNIE	CATHERINE	SAVAGE	May 15, 2002	10:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
301 Caroline Street	Ocean City	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-24-1065	1☐ M 2☒ F	92 Yrs.			April 10,1910	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Ocean City	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
301 Caroline Street	21842	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	-	Homemaker	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jackson Bunting	Mary A. Fisher

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joyce R. Shaffer/Daughter	12920 Riggin Ridge Rd., Ocean City, MD 21842

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Sunset Memorial Park	5/18/02	Berlin, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Pneumonia	
	Due to (or as a consequence of): c. CVA	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D0030614	5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1205 Pemberton Dr Suite 101 Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4/AP

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18294

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Henry Saby

2. Date of Death: Month MAY Day 19 Year 2002

3. Time of Death: 2:30 AM

4a. Facility Name (If not institution, give street end number): MARINER HEALTH - BELAIR

4b. City, Town, or Location of Death: BELAIR

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 469-28-4535

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 31, 1931

9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 46 Green Avenue

10f. Zip Code: 21001

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Vietnam Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Military

16b. Kind of Business/Industry: U.S. Army

17. Father's Name (First, Middle, Last): Ray Backmeyer

18. Mother's Name (First, Middle, Maiden Surname): Harriet Muehlberg

19a. Informant's Name/Relationship (Type, Print): William A. Gross (P.O.A.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4137 Oak Dr., Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens

Date: 5/23/02

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Kirsten Angelbeck

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Pneumonia — about one week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Extensive Brain Metastasis from Melanoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Manuel M. Lazaro MD

29c. License number: D19583

29d. Date signed (Month, Day, Year): May 19, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MANUEL M. LAZARO MD 8 Law Street Aberdeen, Maryland 21001

State Registrar

31. Date filed (Month, Day, Year): MAY 20 2002

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SABY, RICHARD

Division of Vital Records, P.O. Box 68760,

10 x1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julia (nmn) Szerdi
2. Date of Death (Month, Day, Year): May 18, 2002
3. Time of Death: 9:35 AM
4a. Facility Name (If not institution, give street and number): Hart Heritage
4b. City, Town, or Location of Death: Street
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 101-26-3171
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 31, 1910
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 1804 Redfield Road
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed
16b. Kind of Business/Industry: Housekeeper

17. Father's Name (First, Middle, Last): John (nmn) Pulicke
18. Mother's Name (First, Middle, Maiden Surname): Anna (nmn) Lipcoey

19a. Informant's Name/Relationship (Type, Print): Sylvia J. Thomas / PR
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 1209 Boyd Road, Street, MD 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Raymond Hill Cemetery
Date: 5-21-02
20c. Location - City or Town, State: Carmel, New York

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — years
Due to (or as a consequence of):
b. Congestive heart failure — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco uee contribute to the cause of deeth? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Boarding home
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyeicien:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D0018779
29d. Date signed (Month, Day, Year): May 20, 2002

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Albert S.C. Sun, M.D., 1716 Harford Rd., Suite 105, Fallston, MD 21047

State Registrar

31. Date filed (Month, Day, Year): MAY 2 1 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item# 23a Per Phy. 5/22/2002 **Certificate of Death** HCHD LM Reg. No. 2002 18296

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John W. Sharkey
2. Date of Death Month: 05 Day: 17 Year: 2002
3. Time of Death: 2:20 AM
4a. Facility Name (If not institution, give street and number): University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-34-8258
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 15, 1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1203 Mill Creek Road
10f. Zip Code: 21047
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1956-1962
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Worker
16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): John Smith Sharkey
18. Mother's Name (First, Middle, Maiden Surname): Blanche Kimball

19a. Informant's Name/Relationship (Type, Print): Mrs. June M. Sharkey (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1203 Mill Creek Rd., Fallston, MD 21047

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Mem'l
Date: 5/20/02
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ~~Intra abdominal sepsis / cholangitis~~ chloangitis — one month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ~~End stage liver disease s/p orthotopic liver transplant~~ Due to (or as a consequence of): s/p orthotopic liver transplant
c. Due to (or as a consequence of):
d. end stage liver disease

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
acute renal failure

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] CJ Bucci MD
29c. License number: P14147
29d. Date signed (Month, Day, Year): 05-17-2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CJ Bucci University of Maryland Medical System Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18297

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Minnie B. Taylor
2. Date of Death: Month May Day 20 Year 2002
3. Time of Death: 12:35P M
4a. Facility Name (If not institution, give street and number): 12704 Princeleigh St.
4b. City, Town, or Location of Death: Upper Marlboro
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 354-07-8516
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 6, 1918
9. Birthplace (State or Foreign Country): Mississippi

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12704 Princeleigh Street
10f. Zip Code: 20774
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Secretary
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Louis H. Shelby
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Gail D. Taylor - Grand-daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4019 - 5th St., N.W. Wash., DC 20011

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: 5/28/2002
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Cholangiocarcinoma

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Dpinder Singh
29c. License number: D45600
29d. Date signed (Month, Day, Year): 5-22-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dpinder Singh, M.D. 14300 Gallant Fox Lane, Suite 124, Bowie, MD 20715

CR (10)

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002
32. Registrar's Signature: Bryan D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 | 8298

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Wylie Thompson	May 16, 2002	11:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
445-01-2447	1☒ M 2☐ F	84 Yrs.			June 17,1917	Georgia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Suitland	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3205 Ryan Drive	20746	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Store Keeper	U.S. Navy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clarke Thompson	Effie M. Motley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Helen M. Thompson (Wife)	3205 Ryan Drive Suitland, Maryland 20746

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Maryland Veterans Cemetery	May 24, 2002	Cheltenham, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	~ 1 mon
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶	29c. License number	29d. Date signed (Month, Day, Year)
	D-29097	5/20/2002.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gungan Vador, M.D. 3060 Mitchelleville Rd. Bowie, Md. 20715

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	

CR 10

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN TAKEALL
2. Dete of Deeth: Month May, Dey 10, Year 2002
3. Time of Death: 11:25 p.m.
4a Fecility Neme (If not institution, give street end number): Heartland Healthcare of Hyattsville
4b. City, Town, or Location of Deeth: Hyattsville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 249-40-0722
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Aug. 31, 1920
9. Birthplace (State or Foreign Country): South Carolina

Usuel Residence of Decedent

10a. State: D. C.
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 5225 Central Avenue, S. E.
10f. Zip Code: 20019
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant
16b. Kind of Business/Industry: Nursing Home

17. Fether's Name (First, Middle, Last): William Barnwell
18. Mother's Name (First, Middle, Maiden Surname): Josephine Magwood

19a. Informent's Name/Reletionship (Type, Print): Alice Smith (Niece)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5224 Central Avenue, S. E. Washington, D. C. 20019

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood Cemetery
Date: 5-18-02
20c. Location - City or Town, State: Washington, D. C.

21. Signature of Funeral Service Licensee: Wanda C. Bacon 000361
22. Name and Address of Facility: W. H. Bacon Funeral Home, Inc. 3447 14th St., N.W. Washington, D. C. 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease years

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D01852
29d. Date signed (Month, Day, Yeer): May 13 2002

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): PAUL A. DENORE MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18300

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Hazel	Marie	Taylor	May 16 2002	01:00 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
232-62-6226	1 ☐ M 2 ☒ F	91 Yrs.			Jun 3, 1910	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Mineral	Ridgeley	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Route 3 Box 325	26753	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		homemaker	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry F. Ash	Sarah (Gross)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lorraine Davis daughter	HC 86 Box 23; Fort Ashby WV 26719

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Pleasant Cemetery	5/19/2002	Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	24 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Coronary artery disease	5 yrs
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Paul S. Livengood MD	D23774	MAY 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAUL T. LIVENGOOD MD 912 SETON DR. CUMBERLAND MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	Jeanne G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18301

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Alice	Louise	Thomas	MAY	25	2002	3:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	CUMBERLAND	ALLEGANY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-26-9932	1☐M 2☒F	73 Yrs.			Mar 17, 1929	KY

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Cumberland	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
229 Baltimore Avenue Apt. 409	21502	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Herbert A. Bryant	Cora M (Harris)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert A. Thomas son	14700 Barton Blvd.;Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sunset Memorial Park	5/29/ 2002	Cumberland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J. Scarpelli	Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE SUPERIOR MESENTERIC THROMBOSIS	1 DAY
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robustiano J. Barrera, Jr.	D-14865	MAY 25TH, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Robustiano Barrera M.D. 500 Memorial Avenue Cumberland,Maryland 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended # 24A-26
05/29/02, Allegany Co. MLO

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosalie E. Taylor

2. Date of Death Month Day Year: MAY 25,2002

3. Time of Death: 08:42 AM

4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-14-6447

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 22,1921

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: LaVale

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1245 Braddock Road

10f. Zip Code: 21502

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Alfred Smith

18. Mother's Name (First, Middle, Maiden Surname): Grace Dixon

19a. Informant's Name/Relationship (Type, Print): Bev Bonarigo - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12308 Butler Drive, LaVale, MD 21502

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park

Date: May 29,2002

20c. Location - City or Town, State: ~~Cumberland, MD~~

21. Signature of Funeral Service Licensee: Douglas A Hafer

22. Name and Address of Facility: Hafer Funeral Service, PA
1302 National Hwy, LaVale, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Left Ventricular Hypertrophy

Approximate Interval Between Onset and Death: 5years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MAEM

29c. License number: 054765

29d. Date signed (Month, Day, Year): MAY 29 ,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Robert E. Rapp, 912 Seton Drive, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

MC 6

Calvin E. Truax, Jr.
CJ
02-2751-043

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrer

Certificate of Death

Reg. No. 2002 18303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Calvin Edward Truax, Jr.	May	27	2002	01:05 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
End of Ankeny Lane	Clear Spring's	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-64-2364	1☒M 2☐F	45 Yrs.			Sept. 23, 1956	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Washington	Clear Spring	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12120 Big Pool Road	21722	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Maintenance	Cola Bottling Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Calvin Edward Truax, Sr.	Mary Louise Deneen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donna Truax-Wife	P.O. Box 90 Clear Spring, MD 21722

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Lawn Mem. Park	5-31-02	Hagerstown, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Osborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 21795

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARBON MONOXIDE INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	5/27/02 FOUND	FOUND 1115 AM	1☐Yes 2☒No	SUBJECT PLACED HOSE ATTACHED TO EXHAUST PIPE IN VEHICLE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): VEHICLE NEAR ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State): END OF ANKENY LANE, CLEAR SPRING, MD

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E.	May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18304

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH CONWAY TAYLOR
2. Dete of Deeth: Month May, Dey 15, Year 2002
3. Time of Death: 8:50 PM
4a. Fecility Neme (If not institution, give street end number): Salisbury Rehab & Nursing Center
4b. City, Town, or Location of Death: Salisbury, Md.
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 213-16-2353
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 81 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): March 25, 1921
9. Birthplece (State or Foreign Country): New Jersey

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Wicomico
10c. City, Town or Location: Delmar
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 8614 N. Prong Lane
10f. Zip Code: 21875
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: Coast Guard
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+): -
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Power Room Foreman
16b. Kind of Business/Industry: C & P Telephone Co.

17. Fether's Neme (First, Middle, Last): Boardman W. Taylor
18. Mother's Name (First, Middle, Maiden Surname): Hazel Karge

19a. Informant's Name/Relationship (Type, Print): Evelyn Taylor/Wife
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 8614 N. Prong Lane, Delmar, MD 21875

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Ft. Lincoln Cemetery
Dete: 5/20/02
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Keith A Dewey CFSP
22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — months
Due to (or as a consequence of):
b. Chronic obstructive Pulmonary disease — yrs.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier
29c. License number: 027349
29d. Date signed (Month, Dey, Yeer): 5/16/02

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): WILLIAM ROBINS, M.D.,1104 HEALTHWAY DR.,SALISBURY, MD 21804

State Registrar

31. Dete filed (Month, Day, Year): MAY 20 2002
32. Registrar's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

TAYLOR, KENNETH
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the buriel-transit

1VA 10MD

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18305

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Oscar Bryant Williams	May 21, 2002	09:46A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring, MD	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
239-32-3939	1 [X] M 2 [ ] F	75 Yrs.			July 24, 1926	Rocky Mt.,NC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
D.C.		Washington, DC	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1427 West Virginia Ave,NE	20002	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Construction

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Williams	Sally Willoughby

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Naomi Peebles Williams	1427 West Virginia Ave,NE, Washington,DC 20002

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Ft. Lincoln Cemetery	May 29, 2002	Bladensburg, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Larry L. Simmons	Pope Funeral Homes 2617 Pennsylvania Ave,SE,Washington,DC 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Septicemia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Steve Gr MD	D24348	5. 21. 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Grafferman MD 1500 Forest Glen Road, Silver Spring, Md. 20910

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	Steven G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Cf 8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Wallace

2. Date of Death: Month May, Day 20, Year 2002

3. Time of Death: 0140

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213-09-7212

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Nov. 9, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No — X

10e. Street and Number: 703 Rosemere Ave.

10f. Zip Code: 20904

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced — X

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — X. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No — X. Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Utility Worker

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Charles Wallace

18. Mother's Name (First, Middle, Maiden Surname): Lucinda Lewis

19a. Informant's Name/Relationship (Type, Print): Rita Richey - Grand-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3420 Hampton Hollow Dr., #3420A, Silver Spring, MD 20904

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) — X

20b. Place of Disposition (Name of cemetery, crematory or other place): Lee's Crematory

Date: 5/28/2002

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., DC 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hematuria

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Seizures

Due to (or as a consequence of):

d. Dementia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown — X

24a. Was an autopsy performed? 1☐ Yes 2☒ No — X

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No — X

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — X. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural — X, 2☐ Accident, 3☐ Suicide, 4☐ Homicide, 5☐ Pending investigation, 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. — X. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kirti Vohra M.D.

29c. License number: D 20274

29d. Date signed (Month, Day, Year): May 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kirti Vohra, M.D. 7710 Bradley Blvd., Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): MAY 2 4 2002

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CR (4)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18307

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Susie Sibert Wells	May	15	2002	3:35 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Future Care Pineview Nursing Home	Clinton	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
141-12-6509	1☐ M 2☒ F	97 Yrs.			09-24-1904	McCormick, SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince Georges	Capital Heights	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4306 Will St	20743	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th		Housewife	Private

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Sibert	Janie Sibert

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Wells	4306 Will St Capital Heights, MD 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Ft. Lincoln Cemetery	05-20-2002	Brentwood, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ K. D. Marshall	JB Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Cardiac Failure	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertensive Heart Disease	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension & Peripheral Vascular Disease

Degenerative Arthritis

Alzheimer's Disease

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Moti Koul	D24020	5/16/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Moti L. Koul, MD 4467 Old Branch Ave Temple Hills, MD 20748

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	▶ Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or **Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR (3)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18308

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Elmer Leon White , Sr.	May 15, 2002	6:35 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1229 Dunbar Oaks Drive	Capitol Heights	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-44-3400	1[X]M 2[ ]F	67 Yrs.			8/14/34	Wash.,D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	P.G.	Capitol Heights	1[X]Yes 2[ ]No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1229 Dunbar Oaks Drive	20743	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1[ ]Never Married 2[ ]Married 3[X]Widowed 4[ ]Divorced	1[ ]Yes 2[X]No If Yes, Give Year or Dates:	1[ ]Yes 2[X]No Specify:	Specify: African-American

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Chef	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown	Lavenia White

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lydia Ann Barbour/companion	1229 Dunbar Oaks Dr.,Cap. Hgts.,Md. 20743

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1[ ]Burial 2[X]Cremation 3[ ]Removal from State 4[ ]Donation 5[ ]Other (Specify)	Chesapeake Crematory,Inc.	5/18/02	Beltsville, Md.

21. Signature of Funeral Service Licensee: Danny W. Oates

22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C. 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	Metastatic Esophageal Cancer	5 Mths
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1[ ]Yes 2[ ]No 9[ ]Unknown	1[ ]Live birth 2[ ]Fetal death 3[ ]Ectopic pregnancy 4[ ]Pregnant at time of death 5[ ]Other (specify) 9[ ]Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1[ ]Yes 2[ ]No 3[ ]Probably 4[ ]Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ]Yes 2[X]No	1[ ]Yes 2[ ]No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1[ ]Yes 2[X]No	Hospital: 1[ ]Inpatient 2[ ]ER/Outpatient 3[ ]DOA Other: 4[ ]Nursing Home 5[X]Residence 6[ ]Other (Specify)

27. Manner of Death: 1[X]Natural 2[ ]Accident 3[ ]Suicide 4[ ]Homicide 5[ ]Pending investigation 6[ ]Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
		1[ ]Yes 2[ ]No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1[X]**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2[ ]**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Mutombo Kankando, MD	D46704	May 17,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mutombo Kankando,M.D. 1221 Mercantile Ln.,Largo, Maryland 20774

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, it is Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

CR (10)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18309

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
BARBARA	WRIGHT	May 17 2002	08:18 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
154-44-0353	1☐ M 2☒ F	50 Yrs.			Nov. 26, 1951	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
WV	Hampshire	Romney	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
690 West Main Street	26757	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2 yrs	Clerk	7-11 Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Gabriel Mirny	Anna Unk.

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robert Troiano Friend	Hc 65, Box 4110, Romney, WV 26757

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Russian Orthodox Convent	May 21 2002	Nanuet, N. J.

21. Signature of Funeral Service License: Frederick W Wampler

22. Name and Address of Facility: Shaffer Funeral Home, 230 East Main St., Romney, WV 26757

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Melanoma	7 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0033280	May 17, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Senil K. Gupta M.D., 625 Kent Ave., Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	Brenda B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

MS

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Joseph Winters

2. Date of Death: Month MAY Day 17 Year 2002

3. Time of Death: 18:42 M

4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-10-9325

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 20, 1918

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Midland

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 19612 Dans Rock Road S.W.

10f. Zip Code: 21532

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Labor

16b. Kind of Business/Industry: Textile

17. Father's Name (First, Middle, Last): James William Winters

18. Mother's Name (First, Middle, Maiden Surname): Theresa Trapp

19a. Informant's Name/Relationship (Type, Print): Rose Marie Mansfield-Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3513 Clayton Road, Joppa,Maryland 21085

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Josephs Cemetery

Date: May 22, 2002

20c. Location - City or Town, State: Midland , Maryland

21. Signature of Funeral Service Licensee: Jana L. McKenzie

22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P.A.,Lonaconing,Md 21539

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. CLOSTRIDIUM DIFFICILE COLITIS — Approximate Interval Between Onset and Death: 1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ISCHEMIC COLITIS, ACUTE MYOCARDIAL INFARCTION, RENAL FAILURE

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vik Poonai

29c. License number: D36766

29d. Date signed (Month, Day, Year): MAY 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIK POONAI, MD 924 SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002

32. Registrar's Signature: Regina G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18311

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH DANIEL WRIGHT
2. Date of Death (Month, Day, Year): May 13, 2002
3. Time of Death: 0813 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 437-18-8027
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8-13-13
9. Birthplace (State or Foreign Country): MISS

Usual Residence of Decedent

10a. State: MD.
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 410 ELIZABETH ST.
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: ARMY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): UNKNOWN
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNKNOWN
16b. Kind of Business/Industry: UNKNOWN

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): WILLIE MAE KENNEDY ~ FRIEND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 410-ELIZABETH ST, SALISBURY, MD. 21801

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CAP VETERAN'S CEM.
Date: 5/20/02
20c. Location - City or Town, State: HURLOCK, MD.

21. Signature of Funeral Service Licensee: ▶ Jennie Cook
22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — Approximate Interval: 2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: H50497
29d. Date signed (Month, Day, Year): 5/13/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTOPHER SNYDER 100 E. CARROLL ST. SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 15 2002
32. Registrar's Signature: ▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Joseph Wright

2+VA PQ

Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amended 5/24/02item # 3 wch/wgn

Certificate of Death

Reg. No. 2002 18312

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
HENRY	T	WYATT	May 12, 2002	7:00a.m. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
512 Truitt Street	Salisbury	Wicomico

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-32-5020	1☒M 2☐F	67 Yrs.			January 24,1935	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
512 Truitt Street	21804	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: Maryland Nat's. Guard	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	-	Animal Health Technician	Maryland Department of Agriculture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James R. Wyatt Sr.	Delena Steele

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathleen L. Wyatt/Wife	512 Truitt St., Salisbury, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Parsons Cemetery	5/15/02	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith R. Dewey CFSP	Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASCVD	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☑Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	H50497	5/14/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Chris Snyder Carroll St., Salisbury, MD

12+HVA DQ

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 15 2002	▶

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18313

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Robert E. Willey, Sr.	May 21, 2002	7:45 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Center	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-20-7526	1☒M 2☐F	75 Yrs.			May 26, 1926	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	Joppa	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
548 Old Joppa Road	21085	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+) 6 years	engineer	electrical contractor

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Willey	Alice Drake Willey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret Willey/wife	548 Old Joppa Road, Joppa, MD 21085

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Dulaney Valley Mem. Gdns	5/25/02	Timonium, Md.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc.
610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary fibrosis, progressive	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic heart disease

Pneumothorax

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Willard P. Amoss	D 004354	May 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Willard P. Amoss, M.D., 2303 Belair Road, Fallston, Md. 21047

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	▶ Geneva G Sparks

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

LM

15

DHMH 17 Rev 1/2001

ORIGINAL

Dewayne E. Yelverton
CJ
02-2605-033

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
DeWayne E. Yelverton	May	19	2002	08:40 P.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
240-37-2265	1☒M 2☐F	19 Yrs.					July 5, 1982	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
District of Columbia		Washington	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4736 Benning Rd., N.E. #203	20019	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Unemployed	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willie R. Herron	Betty J. Yelverton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Betty J. Yelverton - Mother	4736 Benning Rd., N.E. #203, Wash., DC 20019

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Cedar Hill Cemetery	5/25/2002	Suitland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John T. Stewart III	Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GUNSHOT WOUND OF CHEST	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☒Homicide 5☐Pending investigation 6☐Could not be determined	5/19/02	Unknown M	1☐Yes 2☒No	Subject shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street-found	5300 block Southern Avenue S.E., Washington, D.C.

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
David R Fowler	O.C.M.E.	May 20, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CR (2)

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	

DHMH 17 Rev 1/2001

ORIGINAL

02-2981-510
mnmr
Lester Alexander

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2002 18315
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lester Barr Alexander
2. Date of Death: Month June Day 05 Year 2002
3. Time of Death: 17:20pM
4a. Facility Name (If not institution, give street and number): 839 West 36th Street, 2nd Floor
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 233-72-2763
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 48 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 13, 1953
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 839 West 36th Street 2nd fl
10f. Zip Code: 21211
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Specialist
16b. Kind of Business/Industry: Technology

17. Father's Name (First, Middle, Last): Lester Barr Alexander
18. Mother's Name (First, Middle, Maiden Surname): JoAnne James Alexander

19a. Informant's Name/Relationship (Type, Print): Carla Alexander / sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102 West 39th Street., Baltimore, MD 21210

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: June 6, 2002
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature] M00852
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal Hemorrhage
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Chronic Alcoholism
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) at scene

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] J. Aaron Locke, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): June 06, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18316

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cecil E. Ashby

2. Date of Death Month Day Year: May 30 2002

3. Time of Death: 9:55p M

4a. Facility Name (If not institution, give street and number): 9503 B Kings Croft Terrace

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-05-8501

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAy 3 1917

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9503 B Kings Croft Terrace

10f. Zip Code: 21128

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Lenord Jeb Co.

17. Father's Name (First, Middle, Last): Cleveland Ashby

18. Mother's Name (First, Middle, Maiden Surname): Ethel Edwards

19a. Informant's Name/Relationship (Type, Print): Athelene Ashby /wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9503 B Kings Croft Terrace Baltimore MD 21128

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 6/3/02

20c. Location - City or Town, State: Rossville MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Squamous cell carcinoma of the skin — 16 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maura L Gillison

29c. License number: D50498

29d. Date signed (Month, Day, Year): June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Johns Hopkins Oncology Center Baltimore MD

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JOHN	FINNEY	AKINS SR	June	2	2002	10:08a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UPPER CHESAPEAKE MEDICAL CENTER	BELAIR	HARFORD CO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-18-0238	1 XX M 2 ☐ F	78 Yrs.					Sept 9 1923	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HARFORD CO	FALLSTON	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
632 B RECKORD RD	21047	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	1 XX Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 XX No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th grade		EXTERMATOR	PRIVATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
JAMES AKINS	MARY STEWART

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Everhart E. Akins/Wife	632 B Reckord Rd., Fallston, Md., 21047

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Tabernacle U.M.C.	06-07-02	FALLSTON, MARYLAND

21. Signature of Funeral Service Licensee: Charles H Powell

22. Name and Address of Facility: WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD ABERDEEN, MD 21001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE Myocardial infarction	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): CEREBRAL VASCULAR accident	3days
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD, renal failure, Hypertension

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stanley Kinda DO	H41069	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stanley Kinda 1308 Business Center way #102 Edgewood 21040

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

AKINS, John

DHMH 17 Rev 1/2001

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #4b PER PHY G808 6/07/02 JH

Certificate of Death

Reg. No. 2002 18318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Williams Ballard

2. Date of Death (Month, Day, Year): June 7, 2002

3. Time of Death: 5:45 AM

4a. Facility Name (If not institution, give street and number): Gilchrist Hospice

4b. City, Town, or Location of Death: TOWSON ~~Towson~~

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 001-14-3799

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 2, 1914

9. Birthplace (State or Foreign Country): New Hampshire

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1207 Limekin Road

10f. Zip Code: 21286

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Church

17. Father's Name (First, Middle, Last): David E. Williams

18. Mother's Name (First, Middle, Maiden Surname): Harriett A. Ilvaine

19a. Informant's Name/Relationship (Type, Print): Peter Ballard / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1207 Limekin Road., Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 6/7/02

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: M009846

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. obstructive Lung disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD

29c. License number: D25205

29d. Date signed (Month, Day, Year): June 7, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

5:45am 6/7/02 Mildred Ballard,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Blackwell

2. Date of Death Month Day Year: May 31, 2002

3. Time of Death: 2204 M

4a. Facility Name (If not institution, give street and number): Sinai Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 251-32-6646

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 15, 1915

9. Birthplace (State or Foreign Country): S.Carolina

Usual Residence of Decedent

10a. State: S. Carolina

10b. County: N/A

10c. City, Town or Location: North Charleston

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 2529 Appleton Street

10f. Zip Code: 29405

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): San Segar

18. Mother's Name (First, Middle, Maiden Surname): Eva Brown

19a. Informant's Name/Relationship (Type, Print): Corine Atkinson/ niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29405: 4571 Durant Ave N. Charleston, S.Carolina

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Gardens

Date: 6/8/02

20c. Location - City or Town, State: N.Charleston, S.C.

21. Signature of Funeral Service Licensee: Jerry Harvin

22. Name and Address of Facility: Chatman-Harris Funeral Hom 5240 Reisterstown Rd Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure

Due to (or as a consequence of):

b. Diabetes Mellitus

Due to (or as a consequence of):

c. Chronic Renal insufficiency

Due to (or as a consequence of):

d. Anemia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Willie B MV

29c. License number: D5542-

29d. Date signed (Month, Day, Year): 6/4/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Willie B. MVEMBA 2600 Liberty Heights AV Baltimore MD 21244

State Registrar

31. Date filed (Month, Day, Year): JUN 0 7 2002

32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other then 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18320

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
RONALD	BROGAN	JUNE 5, 2002	10:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1052 North Marlyn Ave.	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-40-0038	1 [X] M 2 [ ] F	59 Yrs.			May 27, 1943	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Baltimore	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1052 North Marlyn Ave	21221	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
3		General Laborer	Waste Paper Comapny

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Calvin George Brogan	Marianna Egarden

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth Brogan / wife	1052 North Marlyn Ave., Baltimore, MD 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Chesapeake Crematory	June 7, 2002	Beltsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature] MC0984	CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Squamous Cell Lung Cancer	8 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	RES-000	June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BENJAMIN S. HERMAN MD 601 North Caroline St, Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Bell Benson

2. Date of Death: Month June, Day 2, Year 2002

3. Time of Death: 9:30 PM

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-24-4140 A

6. Sex: 1☐ M 2☐ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 15, 1915

9. Birthplace (State or Foreign Country): Lancaster, SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1420 D Street, N.E.

10f. Zip Code: 20002

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Serice/ Baker

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Frank Bell

18. Mother's Name (First, Middle, Maiden Surname): Delphine Brevard

19a. Informant's Name/Relationship (Type, Print): Ira Benson - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1420 D Street,NE, Washington, DC 20002

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 6/08/02

20c. Location - City or Town, State: Bladensburg, MD

21. Signature of Funeral Service Licensee: #219 ▶ LaVerne E. Montgomery

22. Name and Address of Facility: Latney's Funersl Home 3831 Georgia Ave.,NW, Washington, DC 20011

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 4 days

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b. Pleural Effusion

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

Anemia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wilkinson J. Ninala

29c. License number: D 45285

29d. Date signed (Month, Dey, Year): June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.J. Ninala, 344 University Blvd #113, Silverspring, Md 20901

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2725-027
mnmr
Richard T. Blomquist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEMS #23,PII&27 PER ME. G809 7/17/02 JH

Certificate of Death

Reg. No. 2002 18322

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Richard Blomquist	May 26, 2002	10:40a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9631 Basketring Road	Columbia	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
132-44-9073	1☐M 2☐F	49 Yrs.			October 23, 1952	NY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Howard	Columbia	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9631 Basketring Road	21045	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Administrative Health Care Assistant	Health Care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bernard Blomquist	Haldis Tonnessen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Haldis Louise Benotti / Mother	394 West Turnberry Court, West Chester PA 19382

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Ocean View Cemetery	June 3, 2002	Staten Island, NY

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Victor P. Doda, Jr.	Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOMEGALY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONTRIBUTOTY CHRONIC PANCREATITIS -alcoholism

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medicei Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	May 27, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARYANNE D. KOREN MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Gene Maurice Burston	June 2 2002	1805 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-58-1944	1☒M 2☐F	49 Yrs.			12-24-1952	Md

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3809 Chatham Road	21215	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th grade	N/A	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Earnest Burston	Lucille Hughes

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jacqueline C. Powell - Niece	6913 Blanche Road Balto, Md 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	King Memorial Park	6-8-2002	Randallstown, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert E. Hess	March F/H West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac arrhythmia.	45 min
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CVA.

Unospecified.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☑Yes 2☐No	Hospital: 1☐Inpatient 2☑ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Tariq Khan.	D0021730	June 5 2002.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KHAN, TARIQ Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Burston, Gene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18324

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Karen S. Bennett	June 5 2002	10:45pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
9104 Oswald Way	Rosedale	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-88-6919	1☐ M 2☒ F	39 Yrs.			May 4 1963	Germany

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Rosedale	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9104 Oswald Way	21237	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Seafood Manager	Restaurant

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert B. Bennett	Marlene Dietrich

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MArlene Leary / mother	9104 Oswald Way Baltimore MD 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	OAk lawn Cemetery	6/10/02	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure — Approximate Interval Between Onset and Death: 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Urethral Obstruction — 2 weeks

Due to (or as a consequence of):

c. Recurrent Squamous Cervix Cancer — 2 years

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William P. McGuire	D16801	6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William P. McGuire 9000 Franklin Square Drive

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18325

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
WILLIAM FREEMAN BURKE	June 5 2002	09:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HARFORD MEMORIAL HOSPITAL	HAVRE DE GRACE	HARFORD CO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
497-30-9544	1 [X] M 2 [ ] F	72 Yrs.			NOV 30 1929	MISSOURI

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	HARFORD CO	ABERDEEN	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
514 LAW STREET	21001	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 51/52	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
GED		CIVIL SERVICE	CIVIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALVIN E. BURKE SR	HALEY BURKE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alice L. Burke/Wife	514 Law St., Aberdeen, Md., 21001

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GARRISON FOREST	06-12-02	OWINGS MILLS, MD.,

21. Signature of Funeral Service Licensee: Charles W. Powell

22. Name and Address of Facility: WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPIA BLVD., ABERDEEN MD 21001

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Septic shock.	24hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Perforated peptic ulcer	24hrs
	c. Due to (or as a consequence of): Carcinoma of lung Stage IV	several months
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

liver alcoholic cirrhosis

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D-0014544	June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
IAN SOMERVILLE 400 LEWIS ST HAVRE DE GRACE MD 21078

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18326

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
CAROLYN BONNER	JUNE 1 2002	6:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
7007 Heathcoate Drive	Kingsville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-01-9759	1 ☐ M 2 ☒ F	84 Yrs.			12/6/1917	Baltimore City, Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Kingsville	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7007 Heathcoate Drive	21087	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Years	2 Years	Typist	Montgomery Ward Corperation

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Peter Olkowski	Gertrude Ryniewicz

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nicholas V. Bonner, Jr. (Son)	11809 Cedar Lane Kingsville, Maryland 21087

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Valley Mem. Gardens	June 7, 2002	Timonium, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
E.F.Lassahn Funeral Home
11750 BelAir Road Kingsville, Maryland 21087

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Heart failure	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): mitral regurgitation	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Samuel Dursa MD	D47040	6/3/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAMUEL DURSO MD 4924 Campbell Blvd., Suite 205 Baltimore MD 21236

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Unknown 02-167
02-2913-510
cm
Mark D. Burke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEMS#27,28d per ME G809 071202 SS

Certificate of Death

Reg. No. 2002 18327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Mark D. Burke	June	03	2002	3:40 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-88-4077	1 ☒ M 2 ☐ F	40 Yrs.			12-24-1961	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.		Baltimore	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2301 Maryland Ave.	21218	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	computer repair	computers

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Paul E. Burke, Jr.	Edith Scherer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edith Burke mother	1305 S. Rolling Rd., Catonsville, Md. 21228

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Baltimore Washington Cr.	6/6/02	Laurel, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Yonda L Lemmer	Witzke Funeral Home of Catonsville, Inc, 1630 Edmondson Ave., Catonsville, Md. 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): fall	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined	06-03-02	0306 M	1 ☐ Yes 2 ☑ No	Unknown ~~Deceased jumped from roof~~

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
apartment building	2301 Maryland Ave. Baltimore

29a. Certifier (Check only one)

1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	O.C.M.E.	June 03, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN, M.D 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26 per Ver,G808,06/07/02dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald David Brown
2. Date of Death: Month May Day 28 Year 2002
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): 16 Chestnut Street
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 247-74-8302
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 17 1946
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: FL
10b. County: Orlando
10c. City, Town or Location: Orlando
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 9655 South Orange Avenue
10f. Zip Code: 32804
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Circus

17. Father's Name (First, Middle, Last): Lonnie Brown
18. Mother's Name (First, Middle, Maiden Surname): Mattie Unknown

19a. Informant's Name/Relationship (Type, Print): Thelma Johnson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10601 Josie Place, El Paso, Texas, 79924

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Lawn Memorial Park
Date: June 03 2002
20c. Location - City or Town, State: Anderson, SC

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery disease — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobecco use contribute to the ceuse of deeth?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Montgomery County Fair Grounds ~~16 Chestnut St.~~

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☒ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Patricia L. Tomsko, MD
29c. License number: D51916
29d. Date signed (Month, Day, Yeer): May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patricia L. Tomsko, 11140 Rockville Pike, PMB 348, Rockville, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
GARY	S.	BARRON	MAY	30	2002	10:58 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FRANKLIN SQUARE HOSPITAL	ROSEDALE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
282-48-0049	1 XX M 2 ☐ F	50 Yrs.					AUG. 2, 1951	MI

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	CARNEY	1 ☐ Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1019 NEARBROOK LANE	21234	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced	1 ☐ Yes 2 XX No If Yes, Give Year or Dates:	1 ☐ Yes 2 XX No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	GENERAL MANAGER	BUILDING MORRIS MECHANIC THEATRE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
BLUE BARRON	GERALDINE COTZ

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BLUE BARRON / FATHER	P.O. BOX 1623 - BALTIMORE, MD 21203

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ARLINGTON CHIZUK AMUNO	6/4/2002	BALTIMORE, MD

21. Signature of Funeral Service Licensee: Michael Bruger

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LIVER FAILURE	
Due to (or as a consequence of):	b. Alcoholic CIRRHOSIS	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sepsis, GANGRENOUS gall BLADDER
RENAL FAILURE, HEPATITIS C
ALCOHOL ABUSE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Wassim El-Hitti	P15680	MAY 30 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. WASSIM EL-HITTI 9000 FRANKLIN SQUARE DR. BALTIMORE MD. 21237

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Donna B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2994-510
mnmr
Calvin Cooper

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#18 per fh G808 060702 ss

Certificate of Death

Reg. No. 2002 18330

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Calvin M. Cooper
2. Date of Death Month Day Year: June 06, 2002
3. Time of Death: 6:37 a M
4a. Facility Name (If not institution, give street and number): 351 Gwynn Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-40-4748
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 60 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 8, 1942
9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 351 Gwynn Ave.
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): machinist
16b. Kind of Business/Industry: Box Co.

17. Father's Name (First, Middle, Last): William Cooper
18. Mother's Name (First, Middle, Maiden Surname): ~~Ethel~~ Elcie Chander

19a. Informant's Name/Relationship (Type, Print): Calvin Haskins - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 351 Gwynn Ave. Balto., MD 21229

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 6-11-02
20c. Location - City or Town, State: Lansdowne, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gary P. March Funeral Home P.A. 2410 Fredhilton Pass Balto., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Gastrointestinal Hemorrhage

Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HIV infection

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ Yes 2 ☐ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify): at scene

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): June 06, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18331

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn V. Chambers
2. Date of Death (Month, Day, Year): June 5, 2002
3. Time of Death: 5:30 am
4a. Facility Name (If not institution, give street and number): Harbor Hospital Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-26-5309
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 19, 1929
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore MD
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1325 Andre Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles W. Briggs
18. Mother's Name (First, Middle, Maiden Surname): Violet May Clarke

19a. Informant's Name/Relationship (Type, Print): Russell T. Chambers /Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7707 Norfolk Road, Glen Burnie MD 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) / Date: Cedar Hill Cemetery, June 7, 2002
20c. Location - City or Town, State: Glen Burnie Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Severe Upper G.I. Bleeding	4 hours
Due to (or as a consequence of):		
b.	Gastric Ulcer	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coronary Artery Disease	10 years
d.	C.O.P.D.	10 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia

23b. Did tobacco use contributa to tha cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: U.K. Sunkara M.D
29c. License number: D21187
29d. Date signed (Month, Day, Year): 6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): U.K.SUNKARA, 1600 CRAIN HWY, GLENBURNIE, MD 21061

State Registrar

31. Date filed (Month, Day, Year): JUL 07 2002
32. Registrar's Signature: Donna G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate ba executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for usa as the buriel-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6-5

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18332

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT CRAWFORD
2. Date of Death: Month June Day 2 Year 2002
3. Time of Death: 2:05 PM
4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 219-40-1876
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01 11 45
9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2857 West Lafayette Ave
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade | College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seafood Business
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Dudley Crawford
18. Mother's Name (First, Middle, Maiden Surname): Louise Rollins

19a. Informant's Name/Relationship (Type, Print): Bobby Jean Ashford-Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7202 Bogley Road, Baltimore Md 21244

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 6/7/02
20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.
22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic Encephalopathy
Due to (or as a consequence of):
b. Septicemia
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. End Stage Renal Disease
Due to (or as a consequence of):
d. Hypertensive Cardiovascular disease

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Rosita R. Cruz M.D
29c. License number: D00303355
29d. Date signed (Month, Day, Year): June 2, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROSITA R. CRUZ M.D BON SECOURS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18333

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arlene Eubanks Crump

2. Date of Death Month Day Year: JUNE 3, 2002

3. Time of Death: 925 PM

4a. Facility Name (If not institution, give street and number): Mercy Stella Maris

4b. City, Town, or Location of Death: Balto

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-36-9628

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9-18-1942

9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md

10b. County: Balto

10c. City, Town or Location: Lochearn

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3413 Croydon Road

10f. Zip Code: 21207

10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Dept of Housing

17. Father's Name (First, Middle, Last): James E. Eubanks

18. Mother's Name (First, Middle, Maiden Surname): Marian B. Bailey

19a. Informant's Name/Relationship (Type, Print): Albert James Crump - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3413 Croydon Road Lochearn, Md 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet

Date: 6/10/2002

20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr.

22. Name and Address of Facility: March F/H West 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer. — Approximate Interval: 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): STELLA MARIS AT MERCY

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 40854

29d. Date signed (Month, Day, Year): JUNE 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St. Paul Pl Baltimore MD 21202

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

B-8

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18334

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Avayah Ham Claxton	MAY 29, 2002	7:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Saint Joseph Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1☐ M 2☒ F	Yrs.		28	5-29-2002	Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Balto	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5 Wytchwood Ct	21209	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A	N/A	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James D. Claxton, III	Erica Ham

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Erica Ham - Mother	5 Wytchwood Ct Balto, Md 21209

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	King Memorial Park	6/1/2002	Randallstown, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John B. Johnson Jr.	March F/H West 4300 Wabash Avenue Balto. Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): CARDIOPULMONARY ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of): EXTREME PREMATURITY

b. Due to (or as a consequence of): NON-VIABLE

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M Rawtani MD	D26961	6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEERA RAWTANI, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18335

Christ, George 6/3/02 7:10 pm

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

1. Decedent's Name (First, Middle, Last): GEORGE WILFORD CHRIST			2. Dete of Deeth Month Day Year: June 3, 2002	3. Time of Death: 7:10 PM
4e Fecility Name (If not institution, give street and number): Hospice of Baltimore Gilchrist Center		4b. City, Town, or Location of Death: Towson	4c. County of Death: Baltimore	
5. Social Security Number: 215-09-9254	6. Sex: 1☐M 2☐F X	7. Age (In yrs. last birthday): 84 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): 05/17/1918
9. Birthplace (State or Foreign Country): Maryland				

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Timonium	1☐ Yes 2☒ No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
8 Bertwell Court	21093	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
9		Vice-President	Greenspring Dairy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George W. Christ	Florine Deitz

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Bob Christ/son	373 North Ferry Point Road Pasadena, MD 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Dulaney Valley Mem. Grdns	06/07/02	Timonium, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
S.D. Coster M01122	Rick Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RR

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CAD — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myelodysplastic Syndrome

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D0051926	June 4, 2002

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)
Helen M. Gordon MD 6565 N. Charles St, Baltimore MD 21204

RR 2011

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
JUN 07 2002	

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18336

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kathleen A. Custer
2. Date of Death — Month: June; Day: 05; Year: 2002
3. Time of Death: 7:50 PM
4a. Facility Name *(If not institution, give street and number)*: Hospice of Baltimore, Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-16-2939
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 2, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 Tipperary Court
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Food Manager
16b. Kind of Business/Industry: Baltimore County Public Schools

17. Father's Name *(First, Middle, Last)*: Archie T. Conner
18. Mother's Name *(First, Middle, Maiden Surname)*: Adele P. Grimes

19a. Informant's Name/Relationship *(Type, Print)*: Thomas N. Conner / brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 251 Gralan Road; Catonsville, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parkwood Cemetery — Date: 6/8/02
20c. Location - City or Town, State: Parkville, MD

21. Signature of Funeral Service Licensee: Peter V. Ruck
22. Name and Address of Facility: Ruck Towson Funeral Home, 1050 York Road, Towson, MD 21204

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lymphoma — months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: June 6, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 07 2002
32. Registrar's Signature: Joyce B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

KATHLEEN A. CUSTER Wednesday, June 5th (fifth) 2002 @ 1950 (7:50 PM)
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

RL 6

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18337

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
James L. Duncan	June 5, 2002	5:15 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Heritage/ Genesis Elder Care	Dundalk	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-34-2107	1☒M 2☐F	63 Yrs.			Feb. 4, 1939	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Balto.	Edgemere	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3 Elinor Lane	21219	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: Army	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Machinist	General Motors

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John J. Duncan, Sr.	Agnes Ward

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JoAnn Fram / Sister	3 Elinor LAne, Balto.,Md. 21219

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Balto-Washington Crem	6- 6 -02	LAurel, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto.,Md. 21222

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARCINOMA OF TONGUE	
Due to (or as a consequence of):	b. CEREBROVASCULAR ACCIDENT	
Due to (or as a consequence of):	c. DIABETES MELLITUS	
Due to (or as a consequence of):	d. ASPIRATION PNEUMONIA	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

S/P TRACHEOSTOMY

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	26. Place of Death (Check only one) Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Surinder K Tuli MD	D27188	6/5/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Surinder K Tuli 2 Market Place Dundalk MD 21222

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18338

KNOWN AS: DAVIS, JIMMIE

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JIMMIE LEE DAVIS	JUNE 3 2002	3:28 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL OF BALTIMORE	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
258-54-0098	1☐ M 2☒ F	64 Yrs.			12 23 37	GA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3018 Stranden Road	21230	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes ☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade		Homeworker	OwnHome

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Kinght	Gertha Mae

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judith Eames Daughter	2711 Fisk Road Baltimore Maryland 21225

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mt Zion Cemetery	6-10-02	Dundalk Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Wane	BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Urosepsis — ~7days

Due to (or as a consequence of):
b. Cerebrovascular Accident — ~5days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown	23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	RES 000	JUNE 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NICOLAAS M. GROBLER, MD 2401 W. Belvedere Ave, BALTIMORE, MARYLAND 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ S Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18339

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Eugenia Dockery	May 31 2002	1:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Bayview Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-38-4082	1☐M 2☒F	60 Yrs.			Feb. 4, 1942	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
416 Stefan Court	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10 Years		House Cleaning	Domestic

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Richard Skowski	Josephine Gravels

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Husband Mr. Michael B. Dockery	416 Stefan Ct. Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Hilltop Service Corp.	6/4/2002	Towson, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Johnny L. Duda	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Metastic small cell lung cancer	7 months
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ PQ Forfia MD	RES 000	May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Forfia Bayview Medical Center 4940 Eastern Ave 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Shawn D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 15

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18340

DE ROSA KATHY ELAINE

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathy Elaine De Rosa
2. Date of Death Month Day Year: JUNE 2 2002
3. Time of Death: 11:32 PM

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-72-2236
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 44 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 21, 1957
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 2924 Putty Hill Ave.
10f. Zip Code: 21234
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 1 Year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fitter
16b. Kind of Business/Industry: Pharmaceutical

17. Father's Name (First, Middle, Last): Forest Ball
18. Mother's Name (First, Middle, Maiden Surname): Mary Allen

19a. Informant's Name/Relationship (Type, Print): Mr. Carlos De Rosa (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2924 Putty Hill Ave. Parkville, MD 21234

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park
Date: 6/7/2002
20c. Location - City or Town, State: Dorsey, Maryland

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — Approximate Interval Between Onset and Death: 1week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Colitis — 1week
Due to (or as a consequence of):
c. ACUTE MYELOGENOUS LEUKEMIA — 1week
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D0056296
29d. Date signed (Month, Day, Year): 6/2/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JASON M BIRNBAUM, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: Donna B Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

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RR

(2)

RR 10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
SHARON DILLON	JUNE 3, 2002	6:15 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GILCHRIST CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
232-88-9806	1☐ M 2☒ F	48 Yrs.			6/9/1953	W. Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
W. VA	RALEIGH	BECKLEY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
132 CESSNA STREET	25801	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE		GENERAL MANAGER	RESTAURANT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
KELLY DILLON, SR.	DELLA TREADWAY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MICHELLE MCCLOSKY DAUGHTER	3507 WOODLEA AVENUE BALTIMORE, MD 21214

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SEAVER CREMATORIUM	6/10/02	PRINCETON, W. VIRGINIA

21. Signature of Funeral Service Licensee: ▶ Heather N. Hays

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Non small cell lung cancer	months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Helen M Gordon	D0051926	June 4, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Helen M Gordon MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dillon, SHARON - Monday, June 3rd, 2002 (6/3/02) @ six 45pm (1815)
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francis X. Dewberry
2. Date of Death (Month, Day, Year): June 5, 2002
3. Time of Death: 2:40 pm
4a. Facility Name (If not institution, give street and number): 1115 Granville Rd.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-18-8075
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 13,1926
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: BAltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 1115 GranvilleRd.
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW2
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): parts expeditor
16b. Kind of Business/Industry: parts

17. Father's Name (First, Middle, Last): Frederick Dewberry
18. Mother's Name (First, Middle, Maiden Surname): Dorothea Ruth

19a. Informant's Name/Relationship (Type, Print): Robin Dewberry/son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17302 Pink Dogwood Court, Mt. Airy, Md. 21771

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): New Cathedral Cemetery
Date: 06/08/02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Sonda L Lemmer
22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Atherosclerotic CADz	unkn
Due to (or es e consequence of): b.	Diabetes	yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest — Due to (or es e consequence of): c.	Hypertension	yrs
Due to (or as a consequence of): d.	HyperCholesterolemia	yrs

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner steted.

29b. Signature end title of certifier: ▶ Tom
29c. License number: 051811
29d. Date signed (Month, Day, Yeer): 06/06/2002

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): 1120 N. Rolling Rd Balt MD 21228

State Registrar

31. Dete filed (Month, Dey, Yeer): JUN 07 2002
32. Registrar's Signature: ▶ Bruce B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ector Davis	June 3 2002	9 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4810 EDMONDSON AVENUE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-64-3294	1☑M 2☐F	32 Yrs.			09-20-1969	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4810 EDMONDSON AVENUE	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☑Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10 TH GRADE	N/A	COOK	FOOD SERVICE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
FELTON DAVIS	EARLINE JOHNSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
EARLINE JOHNSON / MOTHER	4810 EDMONDSON AVE. BALTO. MD. 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	DRUID RIDGE	06-08-02	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Vaughn C	VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Bladder Cancer	2½ years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Nancy A Dawson MD	MD D0031586	June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Nancy A. Dawson M.D. Univ. of Maryland, 22 S. Greene St, Baltimore Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18344

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Edna M. Eader	June 4 2002	2:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215.22.1950	1☐ M 2☒ F	88 Yrs.			May 17, 1914	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Catonsville	1☐ Yes 2☒ No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5743 Edmondson Avenue	21228	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married XX 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No XX If Yes, Give Year or Dates:	1☐ Yes 2☐ No XX Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jefferson D. Creager	Frederica S. Korll

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles Coulson/ Son in law	309 Clyde Avenue Lansdowne, MD 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Hill Cemetery	6/7/02	Brooklyn, MD

21. Signature of Funeral Service Licensee ▶ Adam M. Peters

22. Name and Address of Facility: Gary L. Kaufman Funeral Home @ Meadowridge Memorial Park, Inc. 7250 Washington Blvd. Elkridge, MD 21075

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary edema	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	RES-000	June 4 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Alexander Tu Sinai Hospital of Baltimore 2401 West Belvedere Avenue Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ Bonnie G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Eader, Edna

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Easter, Sr.

2. Date of Death: Month: June; Day: 3; Year: 2002

3. Time of Death: 9:39 PM

4a. Facility Name (If not institution, give street and number): 8800 Walther Blvd.;Apt.1-3513 Westwood Ct.

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-18-5943

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 11 1925

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1☐Yes 2☐No — X

10e. Street and Number: 8800 Walther Blvd.;Apt.1-3513 Westwood Ct.

10f. Zip Code: 21234

10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed — X 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes — X 2☐No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No — X Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Locksmith

16b. Kind of Business/Industry: Security

17. Father's Name (First, Middle, Last): Kent Easter

18. Mother's Name (First, Middle, Maiden Surname): Anne Katzenberger

19a. Informant's Name/Relationship (Type, Print): Robert H. Easter, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Lauren Knoll Ct., Baldwin, MD 21013

20a. Method of Disposition: 1☒Burial — X 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens

Date: 6/7/02

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name end Address of Facility: Lemmon Funeral Home, 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction

Due to (or es a consequence of):
b. Ischemic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No — ✓ 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No — ✓

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No — ✓

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

26. Place of Death (Check only one) — Other: 4☐Nursing Home 5☑Residence — ✓ 6☐Other (Specify)

27. Manner of Death: 1☐Natural — ✓ 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. — ✓ 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MP

29c. License number: D35685

29d. Date signed (Month, Day, Year): 6/4/02

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): 8800 Walther Blvd Parkville, MD 21234; Juan Galarraga, M.D.

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18346

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
LeRoy	Elliott	June 1, 2002	1:37 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Hospital	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☐F	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-64-0564	X	45 Yrs.			12 2 56	S.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
214 E. Lafayette Avenue	21202	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		Roofer	RooferCo Wallace& Gale

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Hoppie Mitchell	Dorothy Elliott

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothy Elliott Mother	214 E. Lafayette Avenue Baltimore MD 21202

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Voshell Mem. Gar.	6-6-02	Dundalk Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Warner	BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ K. Harriston	P15899	June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Kristen G. Harriston 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOLORES M. FALES
2. Date of Death (Month, Day, Year): JUNE 5 2002
3. Time of Death: 7:00 P.M

4a. Facility Name (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 217-12-9228
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/15/1923
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: HAMPSTEAD
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19925 GRAVE RUN ROAD
10f. Zip Code: 21074
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8TH GRADE
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: CHARITY ORGANIZATION

17. Father's Name (First, Middle, Last): JOHN BETCH
18. Mother's Name (First, Middle, Maiden Surname): ANNA SIMMONT

19a. Informant's Name/Relationship (Type, Print): PATRICIA GROFT DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19925 GRAVE RUN ROAD HAMPSTEAD, MD 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT CARMEL CEMETERY
Date: 6/8/2002
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic shock — 1 day

Due to (or as a consequence of):
b. Acute renal failure — ~ten days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary artery disease

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 51705
29d. Date signed (Month, Day, Year): 6-6-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. PANSURIYA 419F Malwlm Dr, Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: [signature] S Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

May Fales
Dolores

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #4a,10e,19b&30 per phy g808, 6/07/02

2002 18348 Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALVERTA BERTHA FITCH
2. Date of Death Month / Day / Year: JUNE 1 2002
3. Time of Death: 3:00 P M
4a. Facility Name *(If not institution, give street and number)*: 5629 ~~5609~~ North Lane
4b. City, Town, or Location of Death: Baltimore County
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-18-5630
6. Sex: 1☐ M XX F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 20, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1☐ Yes 2 XX No
10e. Street and Number: 5629 ~~5609~~ North Lane
10f. Zip Code: 21206
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed XX 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 yrs. — College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook
16b. Kind of Business/Industry: Martin's West

17. Father's Name *(First, Middle, Last)*: William Rumpf
18. Mother's Name *(First, Middle, Maiden Surname)*: Mina Roth

19a. Informant's Name/Relationship *(Type, Print)*: Irene E. Mooney (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5629 ~~5609~~ North Lane Baltimore, Maryland 21206

20a. Method of Disposition: XX 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cem.
Date: 6-4-02
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service License: William D Rumpf
22. Name and Address of Facility: Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Severe arteriosclerotic Aortic Stenosis — Approximate Interval Between Onset and Death: > 19yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. end Stage congestive cardiomyopathy — 72yrs
Due to (or as a consequence of):
c. with severe COPD — 73yr
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other *(specify)* 9☐ Unknown
23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hx A Fib; Hx GI Bleeding; Hx Hypothyroidism; Neurologic Disorders

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Michael A Hyle
29c. License number: D27693
29d. Date signed *(Month, Day, Year)*: 6/3/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL A. HYLE 3010 GIBBONS BALTIMORE MD. 21214

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 07 2002
32. Registrar's Signature: Sandra B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

B-4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a per Dr. Sun 808, 06/18/02dhb

For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18349

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Agnes Amelia Fruhling	June	3	2002	2:28 p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Upper Chesapeake Medical Ctr.	Bel Air	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-12-6035	1☐M 2☒F	77 Yrs.			9/10/1924	Baltimore, MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Joppa	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
915 Pine Road	21085	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No *Specify:*	*Specify:* Whiite

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 years	N/A	Housewife	Homemaker

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Grymkiewicz	Julia Baran

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward E. Fruhling, Jr. (son)	915 Pine Road - Joppa, MD 21085

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Gardens of Faith Cemetery	6/7/2002	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	E.F. Lassahn Funeral Home 11750 Belair Road - Kingsville, MD 21087

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 8 days ~~3 months~~

Immediate Cause (Final disease or condition resulting in death): ~~Oesophageal cancer~~ Bacteremia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. ____

Due to (or as a consequence of):

b. Oesophageal — 3 months

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bacteremia.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No	1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ S. Rajaraj. MD	D 53720	06/03/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Rajaraj. 2112 Belair Rd #1, Fallston, MD 21047

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Fruhling, Agnes Amelia

8-5

William Alexander Fowlkes
02-2948-510
crm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18350

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Alexander Fowlkes
2. Date of Death: Month June Day 05 Year 2002
3. Time of Death: 12:30 A M
4a. Facility Name (If not institution, give street and number): Bon Secours Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-14-8674
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 817 N. Calhoun St.
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parking Attendant
16b. Kind of Business/Industry: Parking

17. Father's Name (First, Middle, Last): James Fowlkes
18. Mother's Name (First, Middle, Maiden Surname): Marie Brown

19a. Informant's Name/Relationship (Type, Print): Ms. Louise Fowlkes Harris (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): #1 Hawaii Ave. N.E. #210 Washington, D.C. 20011

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest
Date: 6/12/2002
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): June 05, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

RR

RR 4+1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18351

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
RITA	FELDMAN	JUNE 5, 2002	3:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2503 WILLOW GLEN DRIVE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-32-9663	1☐ M XX F	86 Yrs.			FEB. 18, 1916	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1XX Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2503 WILLOW GLEN DRIVE	21209	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3XX Widowed 4☐ Divorced	1☐ Yes 2X No If Yes, Give Year or Dates:	1☐ Yes 2X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
SAMUEL	LIPSITZ	ESTHER	PLITT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BENJAMIN FELDMAN / SON	5504 ST. ALBANS WAY - BALTIMORE, MD 21202

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SHAAREI TFILOH CEM.	6/6/2002	WOODLAWN, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward C. Rund	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. lung cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2X No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease, hypertension
hyperlipidemia

23e. Did tobacco use contribute to the cause of death? 1X Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2X No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2X No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5X Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1X Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D53968	June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ellie Goldbloom MD 21 Crossroads Drive Suite 400 Owings Mills, MD 21117

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Barbara B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18352

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert E. Fabiszak
2. Date of Death: Month June Day 5 Year 2002
3. Time of Death: 11:20 AM
4a. Facility Name (If not institution, give street and number): Covich Nursing Home
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 217-30-5192
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 8, 1935
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Westowne
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 5717 Edmondson Avenue Apt B5
10f. Zip Code: 21228
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Taxi Driver
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Bernard Fabiszak
18. Mother's Name (First, Middle, Maiden Surname): Josephine Callus

19a. Informant's Name/Relationship (Type, Print): Marilyn Fabiszak / Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5717 Edmondson Avenue Apt. B5 Baltimore, Maryland 21228

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus
Date: 6/8/2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Md. 21231

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — Approximate Interval Between Onset and Death: 1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): Smoking — 30 yrs
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary Kazlow MD
29c. License number: D41617
29d. Date signed (Month, Day, Year): June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary Kazlow MD 10805 Hickory Ridge Rd Columbia Md 21044

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
DELLA GENTRY	6	3	02	12:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Elder Care - Liberty Road	Dundalk	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-10-3172	1 ☐ M 2 ☒ F	97 Yrs.			JUNE 1, 2002	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Dundalk	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
101 Center Place, Apt. 814	21222	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joe Morris	Mattie Morris

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wanda Berlin - granddaughter	1012 Lourdes Rd., Essex, MD 21221

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gardens of Faith	6/07/02	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ M Daugh	Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring Road, Dundalk, Md. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. UROSEPSIS	
Sequentially list conditions, if any, leading to the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL INSUFFICIENCY, DEMENTIA.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Medical Certification: To Be Completed by Physician/Medical Examiner

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D52360	6/4/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUUBIR SANDHU 16356 GREENE TREE RD. SUITE 300 PIKESVILLE MD 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18354

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther Violet Grove

2. Date of Death: Month June, Day 4, Year 2002

3. Time of Death: 8:50 PM

4a. Facility Name (If not institution, give street end number): Mariner Health of Forest Hill

4b. City, Town, or Location of Death: Forest Hill

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 183-05-8779

6. Sex: 1☐ M 2☐ F (XX)

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Jan. 15, 1910

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 109 Forest Valley Drive

10f. Zip Code: 21050

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married (XX) Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Burtus Olphin

18. Mother's Name (First, Middle, Maiden Surname): Laura Runkle

19a. Informent's Name/Relationship (Type, Print): Chester L. Grove, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): R.D. # 2 Felton PA 17322

20a. Method of Disposition: 1☐ Burial 2☐ Cremation (X)☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bethany UM Trinity Cemetery

Date: 06/10/2002

20c. Location - City or Town, State: Felton, PA

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — Few Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Manuel M. MD

29c. License number: D19583

29d. Date signed (Month, Dey, Yeer): June 5, 2002

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): MANUEL M. LAZARO MD 8 Law Street Aberdeen, Maryland (2100)

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18355

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
EZEK GRAY	6 / 5 / 2002	1330 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11 W. 20th St. Apt. 11 U	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-18-9851	1 X M 2 ☐ F	77 Yrs.			8 2 24	VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11 W. 20th Street Apt. 110	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 th Grade		Laborer	United Furnace Co

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Earl Gray	Lillie Washington

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda L. Pettiford Niece	1947 E. 31st Street Baltimore Maryland 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Crownsville Cem.	6-10-02	Crownsville MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Warren	March F.H. East 1101 E. North Ave. Baltimore, Md. 21202

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHF	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. LUNG CANCER	
	Due to (or as a consequence of):	
	c. COPD	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Transitional cancer of the Bladder
Gout, Hemorrhoids, diabetes

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	BH4784511	6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PETR HAUSNER, 10N GREENE STREET, BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	[signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

CM
02-2884-510
MAX GRAYSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #20a-c PERFH G808 6/07/02 JH
UNPENDED 061102:ITEMS#23a,27,28a-f per ME C808 ss

Reg. No. 2002 18356

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Max David Grayson Jr.	JUNE 01, 2002	17:50 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GOOD SAMARITAN HOSPITAL	BALTIMORE	n/a

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-84-4443	1☒M 2☐F	34 Yrs.			Aug.5,1967	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Rosedale	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
105 Lionhead Court	21237	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: AmericanIndian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Artist	Tattoo

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MAx DAvid Grayson	Diane Hatch

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Chebon Grayson /brother	105 Lionhead Court Baltimore MD 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☒Removal from State 4☐Donation 5☐Other (Specify)	~~Bayview Crematory~~ AMERICANBURIAL & CREMATION OF OKLAHOMA CITY	6/07/02	OKLAHOMA CITY ,OK. ~~Baltimore MD~~

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC INTOXICATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☒DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
Found: 6-1-02	Found: 4:45p M	1☐Yes 2☒No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2626 Northern Parkway, Baltimore, Maryland

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	JUNE 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
John M. Gerwig, Jr.	June 3 2002	8 a.m. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3400 N. Ridge Rd., Cottage 409	Ellicott City	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-26-9479	1 [X] M 2 [ ] F	74 Yrs.			05-12-1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Howard	Ellicott City	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3004 N. Ridge Rd., Cottage 409	21043	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1956-1958	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	8	Medical Doctor	Health

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Monroe Gerwig, Sr.	Elizabeth (Birkmeyer)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Louise Gerwig - wife	3004 N. Ridge Rd., Cottage 409, Ellicott City, MD. 21043

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Loudon Park	06-06-02	Baltimore, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Wanda L Lemmer	Witzke Funeral Home/Catonsville 1630 Edmondson Ave., Baltimore, MD. 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia, community acquired	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Congestive Heart failure	years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetel death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Hypertension
Hypercholesterolemia

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ B Lee physician	D-52544	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Benjamin S. Lee, M.D. 700 Geipe Rd #204, Catonsville, MD 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Penny B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #31 PER DVR G808 6/07/02 JH

Certificate of Death

Reg. No. 2002 18358

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other then "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN LELAND GREEN, JR.
2. Date of Death (Month, Day, Year): MAY 26, 2002
3. Time of Death: 7:30p M
4a. Facility Name (If not institution, give street and number): 11509 MANORSTONE LANE
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 244-52-8526
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7-25-1940
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: HOWARD
10c. City, Town or Location: COLUMBIA
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 11509 MANORSTONE LANE
10f. Zip Code: 21044
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married — X 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): -12- / College (1-4or 5+): -8-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HEALTHCARE EXECUTIVE
16b. Kind of Business/Industry: HEALTHCARE

17. Father's Name (First, Middle, Last): JOHN L. GREEN, SR.
18. Mother's Name (First, Middle, Maiden Surname): ESTHER Q. JOHNSON

19a. Informant's Name/Relationship (Type, Print): EDITH GREEN(WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11509 MANORSTONE LANE, COLUMBIA, MARYLAND 21044

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): COLUMBIA MEM. PARK
Date: 5-31-2002
20c. Location - City or Town, State: COLUMBIA, MARYLAND

21. Signature of Funeral Service Licensee: Gwenwere Redd
22. Name and Address of Facility: REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA LUNG — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CIGARETTE ABUSE — Due to (or as a consequence of): — MONTHS
c. — Due to (or as a consequence of): — YEARS
d. —

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
STATUS POST CARCINOMA PROSTATE

23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Anthony Watkins MD
29c. License number: 020754
29d. Date signed (Month, Day, Year): 5/30/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANTHONY E WATKINS, M.D. 106 IRVING ST. NW WASH D.C. 20010

State Registrar

31. Date filed (Month, Day, Year): 5/30/02 JUN 07 2002
32. Registrar's Signature: Geneva B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18359

JOHN HAMILL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): John P. Hamill
2. Date of Death: Month: June Day: 4 Year: 2002
3. Time of Death: 4:25 AM
4a. Facility Name (If not institution, give street and number): Genesis-Cromwell Bridge
4b. City, Town, or Location of Death: Parkville
4c. County of Death: BALTIMORE
5. Social Security Number: 215-01-3269
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-1-16
9. Birthplace (State or Foreign Country): ILLINOIS

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8611 Richmond Ave.
10f. Zip Code: 21234
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12. College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Label Maker.
16b. Kind of Business/Industry: International Paper Co.

17. Father's Name (First, Middle, Last): John P. Hamill, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Martha M. Cheeseman

19a. Informant's Name/Relationship (Type, Print): Patricia D. Myers
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 659 Longs, SC 29568

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery Date: 6/7/02
20c. Location - City or Town, State: Parkville, MD
21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: BALTIMORE, MD 21234 EVANS FUNERAL CHAPEL 8200 HARFORD RD.

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular Accident (Ischemic Stroke) — Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Carotid artery stenosis Subdural bleed 2° CVA Dementia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Martha Raymundo MD
29c. License number: D54518
29d. Date signed (Month, Day, Year): 6/5/2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTHA RAYMUNDO, MD 3007 E. Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item#4c,26 perPHY #10c,10d,19b perHG308 6/12/02EW

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2002 18360

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret C Hood
2. Date of Death: Month June Day 5 Year 2002
3. Time of Death: 12:30 P.M.
4a. Facility Name (If not institution, give street and number): ~~Hold~~ 1519 Ryan Rd.
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-62-6054
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months ___ Days ___
If Under 24 Hrs.: Hours ___ Min. ___
8. Date of Birth (Month, Day, Year): 4-3-13
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3241 Fait Ave.
10f. Zip Code: 21224
10g. Citizen of What Country? USA.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white.

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker.
16b. Kind of Business/Industry: at home.

17. Father's Name (First, Middle, Last): Michael Foertsch
18. Mother's Name (First, Middle, Maiden Surname): Theresa Ebert

19a. Informant's Name/Relationship (Type, Print): Richard Hood
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~Hold~~ 1519 Ryan Rd., Fallston MD 21047.

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem. Date: 6/8/02
20c. Location - City or Town, State: BALTIMORE MD.

21. Signature of Funeral Service Licensee: Krista S. Wells.
22. Name and Address of Facility: BALTIMORE MD. EVANS FUNERAL CHAPEL 8800 HARFORD RD.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pulmonary fibrosis — Due to (or as a consequence of): — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ___ Due to (or as a consequence of):
c. ___ Due to (or as a consequence of):
d. ___

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ___ 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.: cerebrovascular disease

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home ~~5 ☐ Residence~~ 6 ☒ Other (Specify) Son's Residence

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Samuel Durso MD
29c. License number: D47040
29d. Date signed (Month, Day, Year): 6/7/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Samuel J. Durso MD 4924 Campbell Blvd Suite 205 Baltimore MD 21236

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature:

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18361

Elizabeth F. Havrilla 6/4/02 3:20pm

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth F. Havrilla
2. Date of Death: Month 6 Day 4 Year 02
3. Time of Death: 3:20 PM
4a. Facility Name (If not institution, give street and number): Rolling Meadows Assisted Living
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-32-2587
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jun 16, 1907
9. Birthplace (State or Foreign Country): NY

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 7010 Lancaster Road
10f. Zip Code: 21207
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Comptometer Operator
16b. Kind of Business/Industry: Business Operations

17. Father's Neme (First, Middle, Last): John Gresch
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Krelik

19a. Informant's Name/Relationship (Type, Print): John Havrilla/Son
19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code): 7010 Lancaster Road, Baltimore, MD 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: Jun 11 2002
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature] MC0456
22. Name and Address of Facility: Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. Congestive Heart Failure — Years

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Assisted Living

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner as steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: [signature] MD
29c. License number: D36786 Md
29d. Date signed (Month, Day, Year): 6-5-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Katz M.D. 4994 Benworth Rd Columbia Md 21044

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrer's Signature: [signature]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

ADH
SUK HONG
02-2887-003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18362

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Suk Jung Hong	JUNE 1, 2002	1850 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1206 OAK HARBOR	PASADENA	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
561.06.0400	XX 1☑M 2☐F	63 Yrs.			Jan.8, 1939	Korea

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Pasadena	1☐Yes 2☑No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1206 Oak Harbor Court	21122	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2XXMarried 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Self Employed	Store Owner

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
(Unavailable)	(Unavailable)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Neville Hong/ Son	1206 Oak Harbor Court Pasadena, MD 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1XXBurial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Meadowridge Mem. Pk.	6/9/02	Elkridge, MD

21. Signature of Funeral Service Licensee ▶ Leah M Peters

22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge Memorial Park, Inc. 7250 Washington Blvd. Elkridge, MD 21075

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hanging

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
METASTATIC STOMACH CANCER

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	6/1/02	5:47 P M	1☐Yes 2☒No	SUICIDE HANGED SELF

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1206 OAK HARBOR PASADENA, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. M. T.	OCME	JUNE 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

Certificate of Death

Reg. No. 2002 18363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Anna Helene Hess			JUNE 3, 2002	2:15 PMM
4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death		
Saint Joseph Medical Center	Towson	Baltimore		

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-14-4816	1☐M 2☒F	80 Yrs.			April 24, 1922	Baltimore, Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4017 Putty Hill Avenue	21236	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Years	N/A	Homemaker	Housekeeping/Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Mrowca	Bertha Dombrowski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frederick A. Hess (Husband)	4017 Putty Hill Avenue Baltimore, Maryland 21236

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. Joseph's Church Cemetery	June 7, 2002	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Lassahn Funeral Home, Inc. 7401 BelAir Road Baltimore, Maryland 21236

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RENAL FAILURE	2 WEEKS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): COR PULMONALE	15 YEARS
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Beatriz P. Dizon, MD	D 0016492	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BEATRIZ P. DIZON, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Bruce B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18364

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Ann W. Hammond	June 04 2002	2:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Brightwood Center	Lutherville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-05-3254	1☐ M 2☒ F	83 Yrs.			Sept 12 1918	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Lutherville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8206 Tally Ho Rd.	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Benjamin Whiteley	Clarita Dalcourt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ann Brooke/ Daughter	8206 Tally Ho Rd. Lutherville, Md. 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. John Episcopal	6-7-02	Ellicott City, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D19166	6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Alan Baldanza, MD. 10629 York Rd. Cockeysville, Md. 21030

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RR

RR 8

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18365

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Daniel L. Holden, III

2. Date of Death: Month June Day 5, Year 2002

3. Time of Death: 7:30 PM

4a. Facility Name (If not institution, give street and number): 4112 Colby Road

4b. City, Town, or Location of Death: Pikesville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-01-1983

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 21, 1913

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 4112 Colby Road

10f. Zip Code: 21208

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Captain

16b. Kind of Business/Industry: Balto. Co. Fire Dept.

17. Father's Neme (First, Middle, Last): Daniel L. Holden. Jr.

18. Mother's Name (First, Middle, Maiden Surname): Ada B. Wright

19a. Informant's Name/Relationship (Type, Print): Sara W. Holden Wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 4112 Colby Road Pikesville, Maryland 21208

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery

Date: 6/8/02

20c. Location - City or Town, State: Pikesville, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. cardio vascular collapse

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest

b. Respiratory failure

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CVA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier:

29c. License number: H316 15

29d. Date signed (Month, Day, Year): 6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Beeler MD 15 walker Ave Balto. MD 21208

State Registrar

31. Dete filed (Month, Day, Year): JUN 07 2002

32. Registrer's Signature: Lorrie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18366

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Mary Edith Johnson	June 5, 2002	1:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-07-7542	1☐ M 2☒ F	86 Yrs.			Apr. 29, 1916	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Monkton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
17410 Big Falls Road	21111	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade		Cook	Salvation Army

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Isaiah Smith	Amelia Gray

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Courtney H. Johnson /Son	416 Brant Ct. Havre De Grace, Md 21078

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Pine Grove U.M. Church Cem.	6/10/02	White Hall, Md

21. Signature of Funeral Service Licensee: Lucy Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home, 5240 Reisterstown Rd Baltimore, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE MYOCARDIAL INFARCTION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Diabetes Mellitus
- STATUS CATARACT EXTRACTION

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D24100	06-07-2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M. L. PRABHAKAR MD 300 ARMORY PLACE BALTIMORE MD 21203

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Donna B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
Margaret June Jonczak	June 5, 2002	9:15 pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Laurel Regional Hospital	Laurel	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-09-6083	1☐M 2☒F	83 Yrs.			Oct. 28, 1918	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Odenton	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
523 JoAnn Drive	21113	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Cashier	Retail

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Tavenner	Emma Klem

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joan Thornton / daughter	523 JoAnn Drive., Odenton, MD 21113

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Oak Lawn Cemetery	June 8, 2002	Dundalk, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ M00986	CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Myocardial Infarction	minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month Day Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Pancreatitis

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William A Warren MD	D13916	06/06/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William A. Warren 321 Prince Georges Street., Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ Donna B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18368

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beverly Johnson
2. Date of Death (Month, Day, Year): June 2, 2002
3. Time of Death: 1:22 PM
4a. Facility Name (If not institution, give street and number): Mercy Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N. A

Funeral Director

5. Social Security Number: 214 58 5160
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/1/52
9. Birthplace (State or Foreign Country): Md

Usual Residence of Decedent

10a. State: Md
10b. County: N. A
10c. City, Town or Location: Balto
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 209 Beale Ct
10f. Zip Code: 21231
10g. Citizen of What Country?: U. S. A

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PARA-legal
16b. Kind of Business/Industry: Jongye Brooks

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Zona Williams

19a. Informant's Name/Relationship (Type, Print): Ellsworth Johnson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5720 Maple Mill Rd Balto. Md 21239

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cem | Date: 6/5/02
20c. Location - City or Town, State: Balto. Md

21. Signature of Funeral Service Licensee: Joseph B. Locks Jr.
22. Name and Address of Facility: Joseph B. Locks Jr. F/H 1304 N. Central Ave

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary edema — Approximate Interval Between Onset and Death: 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Acute renal failure — 2 weeks

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis C infection

Acquired immune deficiency syndrome

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Pajman Alexander Danai
29c. License number: P14702
29d. Date signed (Month, Day, Year): June 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Pajman Alexander Danai, 22 South Greene St, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RC

RC

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18369

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
NATHANIEL JOHNSON	05-31-2002	3:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5211 BOSWORTH AVE.	GWYNN OAK	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
228-54-8532	1☑M 2☐F	57 Yrs.			08-16-1944	VA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	GWYNN OAK	1☐Yes 2☑No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5211 BOSWORTH AVE.	21207	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☑Married 3☐Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8TH GRADE	N/A	PRINTER	PUBLICATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ANTHONY JOHNSON	MARY JONES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ELSIE JOHNSON / WIFE	5211 BOSWORTH AVE. BALTO. MD. 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	WOODLAWN	06-07-02	BALTO. MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ David C [illegible]	VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE. BALTO. MD. 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. coronary artery Disease

Due to (or as a consequence of):
c. DIABETES mellitus

Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Claudio Levin MD	D27075	6-04-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Claudio LEVIN MD 750 Main St. Reisterstown MD 21136

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ Tonya D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Nancy Lee Kutcher	6 / 6 / 02	12:00 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris	Timonium	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-30-5297	1 ☐ M 2 ☒ F	67 Yrs.			6/9/34	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Parkville	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8623 Wendell Ave.	21234	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Teller	BANK.

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James B. Johnston	Helen H. Holbrook

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Albert J. Kutcher	8623 Wendell Ave, PARKVILLE, MD 21234.

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place) Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Valley MemGardens 6/8/02.	Timonium, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Anita S. Wells	BALTIMORE MD 21234 EVANS FUNERAL SERVICE, 8800 HARFORD RD

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

JUNE 6, 2002 12:00 a.m.

NANCY KUTCHER

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LUNG CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D43725	6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Penny B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#27 PER MD. G808 6-7-02 JAB

Certificate of Death

Reg. No. 2002 18371

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): GEORGE JOHN KRAM,SR.

2. Dete of Deeth (Month, Day, Year): JUNE 5,2002

3. Time of Death: 10:45 pm

4a Fecility Name (If not institution, give street end number): 634 S. FAGLEY STREET

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 217-22-2216

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthday): 92 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): DEC. 22,1909

9. Birthplace (State or Foreign Country): MARYLAND

Usuel Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 634 S. FAGLEY STREET

10f. Zip Code: 21224

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): VENDOR

16b. Kind of Business/Industry: PRODUCE

17. Father's Neme (First, Middle, Last): JOHN KRAM

18. Mother's Name (First, Middle, Maiden Surname): MARGARET DILLER

19a. Informant's Name/Relationship (Type, Print): GEORGE KRAM,JR./SON

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 634 S. FAGLEY STREET,BALTIMORE,MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF JESUS

Date: 6/10

20c. Location - City or Town, State: BALTIMORE,MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET,BALTIMORE,MD. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aatrioslende c Cardiovascular Lyes

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Dementia
- Bronchitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D08358

29d. Date signed (Month, Dey, Yeer): JUNE 7 2002

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Gracia Y. PATRICIO 8903 HARFORD RD BALT. MARYLAND 21234

State Registrar

31. Dete filed (Month, Day, Year): JUN 07 2002

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18372

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Monzella Kneezle

2. Date of Death (Month, Dey, Year): May 29, 2002

3. Time of Death: 6:47 Am

4a. Facility Name (If not institution, give street and number): Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

5. Social Security Number: 495-28-1202

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 10, 1928

9. Birthplace (State or Foreign Country): Missouri

Usuel Residence of Decedent

10a. State: Calif.

10b. County: -

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 9800 Bolsa Avenue

10f. Zip Code: 92683

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Neme (First, Middle, Last): James Nelson

18. Mother's Name (First, Middle, Maiden Surname): Nellie Griffaw Cannon

19a. Informant's Name/Relationship (Type, Print): Christina Lynn Nicosia/Grand-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2070 St. James Road, Marriottsville, Md. 21104

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Lawn

Date: May/30/02

20c. Location - City or Town, State: Covina, Calif.

21. Signature of Funeral Service Licensee: [signature] M20864

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC CANCER TO LIVER — MONTHS

Due to (or as a consequence of):

b. PNEUMONIA — DAYS

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: [signature] MD

29c. License number: 70053150

29d. Date signed (Month, Day, Year): MAY 29th 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAKUNMACA GUPTA 201-109 BACK RIVER NECK RD. BALTIMORE 21221

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18373

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
MARJORIE	Mills	LEE	JUNE 3, 2002	9:45a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2710 ROBIN ROAD	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
244-54-5291	1☐M 2☒F	67 Yrs.			July 30, 1934	NC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Glen Burnie	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2710 Robin Road	21060	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Music Teacher	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ruben Mills	Lillie Martin

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Robin Lee / Daughter	2710 Robin Road Glen Burnie, MD 21060

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Friendship Cemetery	June 9,2002	Wake Forest, NC

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular Accident	4 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Alzheimer's	
	Due to (or as a consequence of): c. Parkinson Disease	
	Due to (or as a consequence of): d. Malnutrition	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☒No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Salvador D. Ramirez M.D.	D0038912	06/04/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SALVADOR D. RAMIREZ M.D. 7845 Oakwood Road #307 Glen Burnie MD. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exam of must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #17 PER FH g808 6/07/02 JH **Certificate of Death**

Reg. No. 2002 18374

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES A LOVE
2. Date of Death: Month MAY Day 12 Year 2002
3. Time of Death: 2:02 AM
4a. Facility Name (If not institution, give street and number): BALTIMORE VA MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-78-4559
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-01-1949
9. Birthplace (State or Foreign Country): NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: GWYNN OAK
10d. Inside City Limits: 1 ☐ Yes 2 ☑ No
10e. Street and Number: 6105 WILMONT DRIVE
10f. Zip Code: 21207
10g. Citizen of What Country? USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECURITY OFFICER
16b. Kind of Business/Industry: PROTECTION

17. Father's Name (First, Middle, Last): ~~RUTHIE HATEY~~ CHARLES LOVE
18. Mother's Name (First, Middle, Maiden Surname): RUTHIE WINSTEAD

19a. Informant's Name/Relationship (Type, Print): RUTHIE HATEY | MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6105 WILMONT DR. #T2, BALTO. MD. 21207

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON FOREST | Date: 05.17.02
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO-NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. UROSEPSIS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. DIABETES Mellitus M.D.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
LEFT SUBCLAVIAN ARTERY DAMAGE

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year): MAY 03 2002
28b. Time of Injury: 1:35 PM
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: CATHETER PLACED IN ARTERY DURING PROCEDURE
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): BALTIMORE VA MEDICAL CENTER
28f. Location (Street and Number or Rural Route Number, City or Town, State): 10 NORTH GREENE ST BALT MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: P13416
29d. Date signed (Month, Day, Year): MAY 30 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHAIM VANEK 10 NORTH GREENE ST BALTIMORE MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #20b PER FH G808 6/07/02 JH

Certificate of Death

Reg. No. 2002 18375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KIMBERLY M. LEWIS

2. Date of Death: Month: June Day: 3 Year: 2002

3. Time of Death: 10 20 A

4a. Facility Name (If not institution, give street and number): LEVINDALE NURSING CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-98-7617

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 35 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02-10-1967

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: GWYNN OAK

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 2113 LUGINE AVENUE

10f. Zip Code: 21207

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH GRADE

College (1-4 or 5+): 2 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TELEMARKETER

16b. Kind of Business/Industry: COMMUNICATIONS

17. Father's Name (First, Middle, Last): CLARENCE SMITH, SR

18. Mother's Name (First, Middle, Maiden Surname): JEANNETTE CHRISTMAS

19a. Informant's Name/Relationship (Type, Print): RODNEY LEWIS, HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2113 LUGINE AVE., BALTO. MD. 21207

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY

Date: 6/11/02 ~~6-10-02~~

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: Vaughn C [illegible]

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Due to (or as a consequence of):

b. End Stage Renal Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anoxic Encephalopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D23767

29d. Date signed (Month, Day, Year): June 3, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Debra J Wertheimer MD 2434 W. Belvedere Ave, Balto, Md 21215

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Kimberly Lewis

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND ITEM #26 PER PHY G808 6/07/02 JH

Reg. No. 2002 18376

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
William Mitchell, Jr.	June 1, 2002	2355 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2301 Cross Country Boulevard	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
227-30-5300	X 1 M 2 F	71 Yrs.			Sept. 7, 1930	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	X 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2610 Oakley Avenue	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th grade		Steelworker	Sparrows Point

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Mitchell, Sr.	Mary L. Knight

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William Mitchell,3rd	6203 Golden Ring Road Baltimore,Md 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Arbutus Memorial Park	6/7/02	Arbutus,Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Gregory Harris	Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore,Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Vascular collapse

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ischemic cardiomyopathy

Due to (or as a consequence of):

c. CAD

Due to (or as a consequence of):

d. CVA

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 X Other (Specify) FRIEND'S HOME

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicida 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Andrew Bekeo MD	43615	June 4 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Bekeo MD 17 Wallen Ave Baltimore maryland 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	James B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To be completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#7&9 PER F.H. G808 6-7-02 JAB

Certificate of Death

Reg. No. 2002 18377

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gladys C. Miller
2. Date of Death: Month 6 Day 02 Year 02
3. Time of Death: 1780 M
4a. Facility Name (If not institution, give street and number): Bayside Care Center
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 239305677
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 88 ~~95~~ Yrs. If Under 1 Year: Months ___ Days ___ If Under 24 Hrs.: Hours ___ Min. ___
8. Date of Birth (Month, Day, Year): 12-20-1913
9. Birthplace (State or Foreign Country): GA. ~~St. Marys Co.~~

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: St. Marys
10c. City, Town or Location: Lexington Park MD
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 21412 Great Mills Road
10f. Zip Code: 20653
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Factory Worker
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Abraham Counts
18. Mother's Name (First, Middle, Maiden Surname): Sara Alma Blackburn

19a. Informant's Name/Relationship (Type, Print): Wanda L. Hunt
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1537 Marshall Street Baltimore MD 21230

20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cem. Date: June 6, 2002
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Victor P. Doda
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Ave. Baltimore MD 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Cerebrovascular occlusion — instant

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Senile Dementia
Bullous emphysema

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: ~~1 ☐ Natural~~ 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ~~1 ☐ Certifying Physician~~: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D19917
29d. Date signed (Month, Day, Year): 6/4/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. James Boyd MD 2000 Wildewood Center California MD 20619

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: Barbara B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2921-510
mnmr
Aaron McCoy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND 062002:ITEMS#23a,27 per ME G808 ss AMEND ITEM#19b per inf G808 061302 ss

Certificate of Death

Reg. No. 2002 18378

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
AARON LEE McCOY SR	June 03, 2002	15:57 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
321 North Stricker Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-72-4861	1☒M 2☐F	43 Yrs.			MARCH 1 1959	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3603 LIBERTY HGTS AVENUE	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12yrs	3yrs	POOL OPERATOR/WSI	BALTIMORE CITY PARKS & RECREATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
TOM LEE McCOY SR	SALLIE ROBINSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda Johnson McCoy/Wife	3603 ~~Libert Hhts~~ Liberty Hgts. Avenue, Baltimore, Maryland 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MT CALVARY CEMETERY	06-10-02	GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Charles R Powell	WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC ALCOHOLISM	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J Pestaner MD	O.C.M.E.	June 04, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Jessica B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18379

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ruth Lee Martin	June 6, 2002	7:45 aM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3060 Westminster St.	Manchester	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-26-8879	1 ☐ M 2 ☒ F	71 Yrs.			June 17, 1930	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Carroll	Manchester	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3060 Westminster St.	21102	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Clerk	U.S. Postal Service

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wilson LaMotte	Mary Royston

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eldridge L. Martin - Husband	3060 Westminster St., Manchester, Md. 21102

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metro Crematory	June 7, 2002	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
J. Garth Eckhardt	Eckhardt Funeral Chapel 3296 Charmil Dr., Manchester, Md. 21102

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Small Cell Lung CA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Breast Cancer

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Teresa Hess	D0051816	6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2973 Manchester Rd Manchester, MD 21102

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Bonnie B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18380

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RONALD G. MARKS SR.

2. Date of Death: Month 5 Day 29 Year 02

3. Time of Death: 915 A M

4a. Facility Name *(If not institution, give street and number)*: UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-48-1391

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 54 Yrs.

If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG. 5, 1947

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: REISTERSTOWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1 SHROPSHIRE COURT

10f. Zip Code: 21136

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TRUCK DRIVER

16b. Kind of Business/Industry: GENERAL DELIVERY

17. Father's Name *(First, Middle, Last)*: SAMEUL MARKS

18. Mother's Name *(First, Middle, Maiden Surname)*: EMMA DAWSON

19a. Informant's Name/Relationship *(Type, Print)*: MARY L. MARKS (FORMER WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 32 LOOMIS COURT, OWINGS MILLS, MARYLAND 21117

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEMORIAL PARK

Date: JUNE 1, 2002

20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: Michele N Vehula MO1241

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE RENAL DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other *(specify)* 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D. Vitberg, MD

29c. License number: P.17664

29d. Date signed *(Month, Day, Year)*: 5/29/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A. VITBERG, MD 22 S. GREENE ST BALTIMORE MD 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JUN 07 2002

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18381

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marguerite A. Mergehenn

2. Dete of Death — Month: June; Dey: 4; Year: 2002

3. Time of Death: 0837

4a Fecility Neme (If not institution, give street end number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 214-12-4130

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 97 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-11-1904

9. Birthplece (State or Foreign Country): MD

Usuel Residence of Decedent

10e. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 711 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12): 4 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): music teacher

16b. Kind of Business/Industry: education

17. Father's Name (First, Middle, Last): Charles Anger

18. Mother's Name (First, Middle, Maiden Sumeme): Catherine Kremp

19a. Informant's Neme/Reletionship (Type, Print): Richard P. Mergehenn, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3457 Nanmark Ct., Ellicott City, Md. 21042

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Baltimore/Wash. Crematory

Date: 6/8/02

20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funeral Service Licensee: Wanda L Lemmer

22. Neme end Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. Metastatic Bladder Carcinoma — Years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Curt W Ollayos MD

29c. License number: D39177

29d. Date signed (Month, Day, Year): June 5, 2002

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Curtis W. Ollayos, M.D. - St. Agnes HealthCare - 900 Caton Avenue - Baltimore, Maryland 21229

State Registrar

31. Dete filed (Month, Day, Year): JUN 07 2002

32. Registrer's Signeture: Donna B Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mentel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Mergehenn, Marguerite A.

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

Certificate of Death

Reg. No. 2002 18382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
EMMA L. MILLS	06-03-2002	6:30 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARINER HEALTH CARE	CATONSVILLE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-16-8371 A	1☐M 2☑F	101 Yrs.			11-12-1900	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
140 POPLAR GROVE ST. # 1E	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7TH GRADE	N/A	SEAMSTRESS	FACTORY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOHN PURNELL	MARIA GINN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NETTIE WAINWRIGHT	140 POPLAR GROVE ST. # 1E BALTO. MD. 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	SHILOH UM CHURCH CEMETERY	06-10-02	JOHNSON NECK, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Vaughn C. Greene	VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. chronic renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. uterine salivary dreams

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death: a. 2yr; b. 10yrs

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D29769	6/4/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

marcelino D. Abueme MD 566 N. Rolling Rd Balto 21228

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18383

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Kenneth Harold Moyer	May 29 2002	10:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
200 Belmont Forest Ct. Unit 402	Timonium	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
201-01-8402	1 ☑ M 2 ☐ F	81 Yrs.			9/25/20	PA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Timonium	1 ☐ Yes 2 ☑ No X

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
200 Belmont Forest Ct. Unit 402	21093	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☑ Married X 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5+	Administrative Law Judge	Federal Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Carl Clyde Moyer	Olive Myrtle Deardorf

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ruth Moyer/wife	200 Belmont Forest Ct. Unit 402, Timonium, MD 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Balto. Wash. Crematory	6/3/02	Laurel, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Lowell M. Lemmon	Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. 38 Cal Pistol To Rt Temple	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Terminal Cancer of Bowel With Mestatic Lesions

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown	1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Scene					

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☑ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	5/29/02	Early AM	1 ☐ Yes 2 ☒ No	38 Cal Bullet To Rt Temple

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
At Home	200 Belmont Forest Ct

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Charles F. O'Donnell MD	D-09383	May 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Charles F. O'Donnell MD	111 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Barbara D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #5 PER FH G809 7/05/02 JH

Certificate of Death

Reg. No. 2002 18384

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Theresa	E.	Nizer	June 5, 2002	12:25 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Arden Courts	Lutherville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-36-7983 (7938)	1☐ M 2☒ F	86 Yrs.			Jan 30 1916	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Queen Anne	Grasonville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
119 Bayview at Kent Narrows	21638	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George A. Schleupner	Amelia Shawen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. John Nizer/ Son	119 Bayview at Kent Narrows Grasonville, Md. 21638

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Parkwood Cemetery	6-12-02	Baltimore, Md.

21. Signature of Funeral Service Licensee: Ruth J. Young

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. SENILE DEMENTIA ALZHEIMERS TYPE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

RR

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) ASSISTED LIVING

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Daly CMT

29c. License number: D30433

29d. Date signed (Month, Day, Year): 6/5/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M DALY MD GBMC 6701 N CHARLES ST BALTIMORE MD 21204

RR 10

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: B Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar: AMEND ITEM #27 PER PHY G8086/07/02 JH

Reg. No. 2002 18385

Baltimore, Maryland 21215-0036 Neimiller, Anna

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Marie Neimiller
2. Date of Death (Month, Day, Year): June 2, 2002
3. Time of Death: 10.40 AM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-4311
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1/9/1915
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8014 Duvall Avenue
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Maximilian John Behringer
18. Mother's Name (First, Middle, Maiden Surname): Helena Lammers

19a. Informant's Name/Relationship (Type, Print): Theresa Church/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 Crisfield Road Baltimore MD 21220

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem
Date: 6/5/02
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Baltimore MD 21237

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hip Fracture, Diabetes Type Two, Dementia

Approved 06/03/02 J. Carlton Abbitt Deputy Medical Examiner

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? XX ~~1☒ Yes~~ 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: ~~1☒ Natural~~ 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 5/24/2002
28b. Time of Injury: unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 8014 Duvall Ave Baltimore, MD 21237

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D57255
29d. Date signed (Month, Day, Year): 6/3/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr James J McGovern · 9000 Franklin Square Dr, Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David L. Poole
2. Date of Death: Month June Day 5 Year 2002
3. Time of Death: 9 AM
4a. Facility Name (If not institution, give street and number): Heritage Nursing Center
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Balto.

Funeral Director

5. Social Security Number: 213-09-1705
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Jan 28 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md. | 10b. County: Balto. | 10c. City, Town or Location: Dundalk | 10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 7232 German Hill Rd. | 10f. Zip Code: 21222 | 10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter

16b. Kind of Business/Industry: Construction

17. Father's Neme (First, Middle, Last): Townsend Poole

18. Mother's Name (First, Middle, Maiden Surname): Daisy Mason

19a. Informant's Name/Relationship (Type, Print): Virginia Neal sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 230 Oak St. Dundalk, Md. 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crownsville Vet Cem

Date: June 12, 2002

20c. Location - City or Town, State: Anne Arundel, Md.

21. Signature of Funeral Service Licensee: Carlton C. Douglas

22. Name and Address of Facility: Carlton C. Douglas Funeral Service 1701 McCulloh St. Balto. Md. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GANGRENE RIGHT FOOT — 1 MONTH

Due to (or as a consequence of):
b. PERIPHERAL VASCULAR DISEASE — 15 YEARS

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. CORONARY ARTERY DISEASE — 10 YEARS

Due to (or as e consequence of):
d. ESSENTIAL HYPERTENSION — 30 YEARS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERURICEMIA
DEMENTIA

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh MD

29c. License number: D14160

29d. Date signed (Month, Day, Year): JUNE 7, 2002

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): HARJIT SINGH M.D. 5410-A ~~MOD~~ RITCHIE HIGHWAY, BALTIMORE, MARYLAND 21225

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificete hes been signed by the attending physicien end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL PFEIFFER

2. Date of Death: Month JUNE Day 2 Year 2002

3. Time of Death: 2239

4a. Facility Name (If not institution, give street and number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-03-8500

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.16,1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Windsor Mill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9037 Old Court Road

10f. Zip Code: 21244

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Automotive Technician

16b. Kind of Business/Industry: Exxon

17. Father's Name (First, Middle, Last): William T. Pfeiffer

18. Mother's Name (First, Middle, Maiden Surname): Margaret A. Murk

19a. Informant's Name/Relationship (Type, Print): Robert Lee Pfeiffer Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9037 Old Court Road; Windsor Mill, Maryland 21244

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Wash.Crematory

Date: 6/4/02

20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ANEMIA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Clifford Faber, MD

29c. License number: 024970

29d. Date signed (Month, Day, Year): JUNE 2, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CLIFFORD FABER, MD NORTHWEST HOSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

ORIGINAL

Ronald B. Plumhoff
CJ
02-2976-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 062602:ITEMS#23a,27,28a-f per ME G808 ss

Certificate of Death

2002 18388
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
RONALD PLUMHOFF	June 05 2002	10:55 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
245 South East Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-42-1317	1 X M 2 ☐ F	56 Yrs.			MAR. 21, 1946	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
245 S. EAST AVENUE	21224	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		PAINTER	HOME IMPROVEMENT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LEROY ALBERT PLUMHOFF	LORRAINE KAHLER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LORRAINE McCORMICK/MOTHER	835 CHESACO AVENUE, BALTIMORE, MARYLAND 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ST. STANISLAUS	6/10	BALTIMORE, MD.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HOME
1901 EASTERN AVENUE, BALTIMORE, MD. 21231

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Scene

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 X Could not be determined	Found: 6-5-02	Unknown M	1 ☐ Yes 2 X No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 245 S. East Ave., Baltimore, MD

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. LAron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES A. RAULIS, SR.
2. Date of Death: Month June Day 3 Year 2002
3. Time of Death: 9:38 pm
4a. Facility Name (If not institution, give street end number): Mariner Health of Bel Air
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 491-22-6174
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 3, 1925
9. Birthplace (State or Foreign Country): MISSOURI

Usual Residence of Decedent

10a. State: Maryland
10b. County: HARFORD
10c. City, Town or Location: ABINGDON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2026 FLAGSTONE COURT
10f. Zip Code: 21009
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: W.W.II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12 YRS.
College (1-4or 5+): 4 YRS.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INSURANCE ADJUSTER
16b. Kind of Business/Industry: HARTFORD

17. Father's Name (First, Middle, Last): CHARLES H. RAULIS
18. Mother's Name (First, Middle, Maiden Surname): KATHERINE STARKEY

19a. Informant's Name/Relationship (Type, Print): MARY M. RAULIS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2026 FLAGSTONE COURT, ABINGDON MARYLAND 21009

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVANS FUNERAL CHAPEL — BEL AIR, P.A. Date: JUNE 7, 2002
20c. Location - City or Town, State: FOREST HILL MARYLAND
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EVANS FUNERAL CHAPEL — BEL AIR, P.A. 3 NEWPORT DRIVE FOREST HILL MARYLAND 21050

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — 10 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: MD
29c. License number: D34652
29d. Date signed (Month, Day, Year): June 4, 2002

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrer's Signature:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use es the burial-transit

Raulie Charles

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18390

AMEND ITEM#30 per DVR G808 060702 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gene Roberson
2. Dete of Deeth Month: 6 Dey: 5 Year: 02
3. Time of Death: 12:31 Am
4a. Fecility Neme (If not institution, give street end number): Northwest Hospital
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: MD

Funeral Director

5. Sociel Security Number: 214-56-5954
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 49 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 17, 1952
9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lochern
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3808 Byfield Road
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed
16b. Kind of Business/Industry: disabled

17. Fether's Neme (First, Middle, Last): Gene Roberson
18. Mother's Name (First, Middle, Maiden Surname): Ruth Ann Powell

19a. Informent's Name/Relationship (Type, Print): Nena Roberson /wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3808 Byfield Road Baltimore, Maryland21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Crownsville Veterans Cem.
Date: 6/10/02
20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Chatman-Harris
22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. seizure — 1 hour

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

HTN
Asthma
ETOH Abuse

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: Carol Anne St. Louis, M.D.
29c. License number: D0056266
29d. Date signed (Month, Day, Year): 6/5/02

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): CarolAnne St. Louis, Northwest Hospital, Randallstown, Maryland

State Registrar

31. Date filed (Month, Dey, Year): JUN 07 2002
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
PANSY C. RAY	June 4, 2002	8:46 a M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Joesph Ritchie House	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-38-3064	1 ☐ M 2 ☒ F	87 Yrs.			5 31 15	N.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2814 Keyworth Avenue	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th grade		Self Employed	Daycare

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Tom Alston	Olivia Taylor

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Olivia Dance Granddaughter	4210 Furley Avenue Baltimore Md 21206

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Druid Ridge	6-10-02	Baltimore Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Warren	BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. metastatic lung cancer	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

myocardial infarction

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ E Tso MD	D 24170	June 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E. Tso MD Richey Hospice 820 N. Eutaw St Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ Gladys Brooks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8:46am
6/4/02
Pansy Ray
8-6

Rodney, James Stephen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James S. Rodney
2. Date of Death (Month, Day, Year): June 5 2002
3. Time of Death: 6:15 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-40-5534
6. Sex: 1 ☐ M 2 ☐ F (XX)
7. Age (In yrs. last birthday): 60 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOv. 17 1941
9. Birthplace (State or Foreign Country): MAryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8 King Henry Circle
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Warehouse

17. Father's Name (First, Middle, Last): James C Rodney
18. Mother's Name (First, Middle, Maiden Surname): Edna Deaver

19a. Informant's Name/Relationship (Type, Print): Edna Rodney / mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 King Henry Circle Baltimore MD 21237

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial
Date: 6/10/02
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Anoxic encephalopathy — Approximate Interval Between Onset and Death: 6 days
Due to (or as a consequence of):
b. myocardial infarction — 6 days
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Stuart R. Willes, M.D.
29c. License number: D36663
29d. Date signed (Month, Day, Year): June 5 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stuart R. Willes 9000 Franklin Square drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James E Silk
2. Date of Death: Month JUNE Day 5 Year 2002
3. Time of Death: 5:57 AM
4a. Facility Name (If not institution, give street and number): 9645 Alda Dr.
4b. City, Town, or Location of Death: Parkville.
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-18-4118
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/7/23
9. Birthplace (State or Foreign Country): Maryland.

Usual Residence of Decedent

10a. State: MD. 10b. County: Baltimore 10c. City, Town or Location: Parkville 10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9645 Alda Dr. 10f. Zip Code: 21234 10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Data Processing Supvr.
16b. Kind of Business/Industry: USF+G.

17. Father's Name (First, Middle, Last): Matthew Silk
18. Mother's Name (First, Middle, Maiden Surname): Marie McKenna

19a. Informant's Name/Relationship (Type, Print): Valeria Silk
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9645 Alda Dr. Parkville, MD 21234.

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Highview Mem. Gardens Date: 6/8/02
20c. Location - City or Town, State: Fallston, MD

21. Signature of Funeral Service Licensee: Krista S. Wells
22. Name and Address of Facility: PARKVILLE MD 21234. EVANS FUNERAL CHAPEL 8900 HARFORD RD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer — Approximate Interval Between Onset and Death: 3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A Van Eck MD
29c. License number: D0024632
29d. Date signed (Month, Day, Year): June 07 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID A VAN ECK MD 22 South Greene Street, Baltimore Md 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18394

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip J. Sessa
2. Date of Death (Month, Dey, Year): May 31, 2002
3. Time of Death: 8:05pm
4e. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-68-5929
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months, Deys | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 3, 1957
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. Stete: MD
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 331-A2 Ellsworth Place
10f. Zip Code: 21085
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Taxi Cab Driver
16b. Kind of Business/Industry: Transportation

17. Fether's Neme (First, Middle, Lest): Samuel J. Sessa
18. Mother's Name (First, Middle, Maiden Surname): Patricia Roth

19a. Informant's Neme/Relationship (Type, Print): Patricia J. Sessa / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 Tea Rose Drive, Baltimore MD 21220

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BayView Crematory
Date: June 3, 2002
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Aortic Insufficiency — hours
Due to (or as a consequence of):
b. SubAcute Bacterial Endocard. Fis — weeks

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Restrictive Lung Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D17118
29d. Date signed (Month, Day, Year): Jun 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz M.D. 7700 York Road 21204

State Registrar

31. Date filed (Month, Day, Yeer): JUN 07 2002
32. Registrer's Signature: Gendra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18395

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Calvin Weldon Sample, Sr	JUNE 02 2002	1:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. AGNES HEALTH CARE	BALTIMORE	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
227-24-0727	1 [X] M 2 [ ] F	73 Yrs.			10-27-1928	Va

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Balto	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2158 Lorraine Avenue	21207	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6th grade	N/A	Steel Worker	Bethlehem Steel

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Leroy Joyner	Adell Downing

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sharon Young - Daughter	4248 Flowerton Road Balto, Md 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Garrison Forest Vet	6-10-2002	Owings Mills, Md

21. Signature of Funeral Service Licensee: Wayne B. Keke

22. Name and Address of Facility: March F/H West, 4300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PULMONARY EDEMA	DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE	MONTHS
	Due to (or as a consequence of): c. ATHEROSCLEROSIS HEART DISEASE	YEARS
	Due to (or as a consequence of): d. HYPERTENSION	YEARS

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	15626	JUNE 02, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TUN NYUNT, St. AGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME SAMPLE, CALVIN

Howard Smith
02-2929-510
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18396

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
Howard	Smith	June	04	2002	1:09 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-86-7625	X M 2 F	29 Yrs.			2 7 73	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4031 TwinCircle Way	21227	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade		Never Worked	NA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Howard A. Smith Sr.	Brenda Eley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shunane Shuron	4031 TwinCircle Way Baltimore MD 21227

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	King Mem. Pk	6-8-02	Randallstown MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Warner	BALTIMORE MARYLAND 21202 MARCH F.H. EAST 1101 E. NORTH AVENUE

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Gunshot Wounds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ✓ Yes 2 No	1 ✓ Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 X Yes 2 No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 X Homicide 5 Pending investigation 6 Could not be determined	6/4/02	12:19 AM	1 Yes 2 ✓ No	Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State): 300 Block E. 20th St. Baltimore, Maryland

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J Pestaner, M.D	O.C.M.E.	June 04, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ Shawn G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia Sue Smith

2. Date of Death: Month: June Day: 4 Year: 2002

3. Time of Death: 7:45a.m.

4a. Facility Name (If not institution, give street and number): Franklin Woods Meridian Nursing Ctr.

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 493-20-7832

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 14, 1927

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 8075 Park Haven Road

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 10 Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Louis S. Bouyea

18. Mother's Name (First, Middle, Maiden Surname): Verna Davis

19a. Informant's Name/Relationship (Type, Print): Pamela S. Knell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 Watertons Way Joppa, Maryland 21085

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gdns. Date: 6/8/2002

20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee: Dan C. Caudell

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Stroke

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Global aphasia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Tom Edmondson MD

29c. License number: D45766

29d. Date signed (Month, Day, Year): June 4, 2002

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Tom Edmondson, 9105 Franklin Square Dr. Ste 312, Baltimore, MD 21237

State Registrar

31. Dete filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If Item 27 is marked other than "natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attanding physicien end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

RR

RR 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar Amend Item#7 per DVRG808 6/12/02 EW

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2002 18398

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Ray Scarborough
2. Date of Death: Month JUNE Day 01,20 Year 02
3. Time of Death: 0627 AM
4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center
4b. City, Town, or Location of Death: Bel Air, MD
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-24-8717
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2/4/1929
9. Birthplace (State or Foreign Country): USA- MD

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2510 Claret Drive
10f. Zip Code: 21047
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4or 5+): 4 Years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Westinghouse Corp.

17. Father's Name (First, Middle, Last): John Scarborough
18. Mother's Name (First, Middle, Maiden Surname): Pauline (LAST NAME UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): Therese Scarborough (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2510 Claret Dr. - Fallston, MD 21047

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Highview Memorial Park
Date: 6/5/2002
20c. Location - City or Town, State: Fallston, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: E.F. Lassahn Funeral Home Kingsville, MD 21087 - 11750 Belair Road

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIOMYOPATHY, CONGESTIVE — 3mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. Atherosclerotic coronary artery disease — 3mos
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes, peripheral vascular disease renal insufficiency, prostate cancer

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Kwan DO
29c. License number: H41069
29d. Date signed (Month, Day, Year): June 1, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Stanley Kwan 1308 Business Center Way #102 Edgewood 21040

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Scarborough, Donald Ray

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
James Elmer Sensel	June 2 2002	17:27 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington County Hospital	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
705-14-2259	1☒M 2☐F	84 Yrs.			October 12, 1917	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington	Hagerstown	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
18634 Carolyn Street	21742	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Assembler	Truck Manufacture

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jacob Elmer Sensel	Rose Izora Shives

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dolores Y. Creek/Niece	281 West Main Street Hancock, MD 21750

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Damascus Cemetery	06/06/02	Big Cove Tannery, PA

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: Grove Funeral Home, P.A. 141 West Main Street Hancock, MD 21750-0368

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RESPIRATORY FAILURE	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PNEUMONIA	14 DAYS
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC HEART DISEASE

DIABETES MELLITUS, TYPE II, WITH PERIPHERAL VASCULAR DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D01040	06-03-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BARRY COHEN, 322 E. ANTIETAM ST, HAGERSTOWN, MD 21740

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	[signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Sensel, James Elmer

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#2 PER MD. G808 6-7-02JB **Certificate of Death** Reg. No. 2002 18400

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Laura Szabelski	June ~~30~~ 03, 2002	8:53 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Canton Harbor Future Care	Baltimore,	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-05-4310	1☐M 2☑F	84 Yrs.			October 2 1917	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1925 Bank Street	21231	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Charwoman	State Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Wisniewski	Frances Unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Thomas Wisniewski / Son	7819 Rock Bourne Road Baltimore, Md. 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holy Rosary Cemetery	June 6, 2002	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
David J. Weber	David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic Heart Disease	≥ 5 yrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Atherosclerosis	≥ 5 yrs
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal failure

Diabetes Mellitus

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D11150	6/6/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	[signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner is not to be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18401

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Roberta Sands
2. Date of Death (Month, Day, Year): June 3, 2002
3. Time of Death: 9:55 pm
4a. Facility Name (If not institution, give street and number): Gilchrist Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: BAltimore

Funeral Director

5. Social Security Number: 215-24-4646
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 11, 1927
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD.
10b. County: Howard
10c. City, Town or Location: Woodbine
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 14845 Bushey Park Rd.
10f. Zip Code: 21797
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): James Johnson
18. Mother's Name (First, Middle, Maiden Surname): Gladys Henry

19e. Informant's Name/Relationship (Type, Print): Maggie Roberta Sands/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5521 Green Dory Lane, Columbia, Md. 21044

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balt./Wash. Crematory
Date: 06/07/02
20c. Location - City or Town, State: Laurel, MD.

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Road, Columbia, Md. 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death)	a. PANCREATIC CANCER	months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): June 4, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): W.A. Riley GBMC 6701 N. Charles St. Balto. md 21204

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: D Spraker

DHMH 16 Rev 6/95

ORIGINAL

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020 (6/3/02) @ 2155 (9:55PM)

SANDS, MARTHA MONDAY, June 3rd, 2002
Division of Vital Records, P.O. Box 68760,

#10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar 6-25-02 JAB AMEND ITEM#17 PER F.H. G808 **Certificate of Death**

Reg. No. 2002 18402

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
PAULITA SNELL	JUNE 4 2002	10:50 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Northwest Hospital	Randallstown	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
229-24-3779	1☐M 2☑F	84 Yrs.			08-28-1917	Va.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Woodlawn	1☐Yes 2☑No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3213 Blue Hill Road	21207	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☐Yes 2☑No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7th	N/A	Beautician	Hair care

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Paul ~~Williams~~ WYMS	Virginia Belle Hines

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Blanch Parker (daughter)	3213 Blue Hill Rd. Woodlawn, MD. 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	SUNRISE CEMETERY	06-01-02	PULASKI COUNTY, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Vaughn C Greene	Vaughn C. Greene Funeral Ser. 5151 Balto Nat'l Pike Balto. MD. 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HYPOTENSION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. PERITINITIS	
	Due to (or as a consequence of): c. PERFORATED VISCUS	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ K SRAO. M.O	D 43462	JUNE, 4, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K.S.RAO. M.O
NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	▶ Joyce D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18403

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROXANNE GUARY TANN
2. Date of Death — Month: June, Day: 5, Year: 2002
3. Time of Death: 9:02 am
4a. Facility Name *(If not institution, give street end number)*: HARFORD MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: HAVRE DE GRACE
4c. County of Death: HARFORD CO

Funeral Director

5. Social Security Number: 219-74-7214
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 43 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 7 1959
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD CO
10c. City, Town or Location: ABERDEEN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 201 PLAZA CT APT 1A
10f. Zip Code: 21001
10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12yrs; College (1-4or 5+): 2yrs
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: DISABLED
16b. Kind of Business/Industry: N/A

17. Father's Neme *(First, Middle, Last)*: HARVEY GUARY
18. Mother's Name *(First, Middle, Maiden Sumame)*: CECELIA GUARY

19a. Informant's Name/Relationship *(Type, Print)*: Roosevelt M Tann/Husband
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 201 Plaza Ct Apt 1A, Aberdeen, Md., 21001

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: BERKELEY CEMETERY
Date: 6-14-02
20c. Location - City or Town, State: DARLINGTON, MARYLAND

21. Signature of Funeral Service Licensee: Charles H. Powell
22. Name and Address of Facility: WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. sepsis syndrome	24 hours
Due to (or as a consequence of):	b. urinary tract infection	24 hours
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last — Due to (or as a consequence of):	c. urinary retention	5 years
	d. multple sclerosis	5 years

Part II. **Other signficent conditions** contributing to death but not resulting in the underlying cause given in Part I.: osteoporosis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physicfen:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medicat Examfner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Prashant Shukla MD
29c. License number: D0004805O
29d. Date signed *(Month, Dey, Year)*: 6/5/02

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Prashant Shukla, M.D. 319 South Union Avenue Havre de Grace MD 21078

State Registrar

31. Dete filed *(Month, Dey, Year)*: JUN 07 2002
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

6/5/02 9:02

Tann, Roxanne Celestine

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18404

AMEND ITEM#5 per fh G808 061802 ss

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALTA MARIE TAXIARHOU

2. Date of Death (Month, Day, Year): May 31, 2002

3. Time of Death: 10:20 PM

4a. Facility Name (If not institution, give street and number): 7530 Main Street. Apt. B

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: ~~220-46-7062~~ 216-03-6936

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb.22, 1947

9. Birthplace (State or Foreign Country): MD

Usuet Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 7530 Main Street Apt. B

10f. Zip Code: 21784

10g. Citizen of What Country?: USA

11. Maritaf Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American tndian, Black, White, etc. Specify: white

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 3

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Correctional Officer

16b. Kind of Business/Industry: House of Correction

17. Father's Neme (First, Middle, Last): Wilson William Hoerichs

18. Mother's Name (First, Middle, Maiden Surname): Margaret Ann Shelton

19a. fnformant's Name/Relationship (Type, Print): Wilson N. Taxiarhou - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3406 Hopkins Ave., Baltimore, MD. 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Memorial Gards.

Date: 06-04 2002

20c. Location - City or Town, State: Marriottsville, MD.

21. Signature of Funeral Service Licensee: ▶ Kim Schlageter MD 25

22. Name and Address of Facility: Witzke Funeral Home of Catonsville 1630 Edmondson Ave., Baltimore, MD. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death): a. VA/unclear heart Disease — yrs

Due to (or as a consequence of): b. S/p mitral valve replacement — ~10 yrs

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es e consequence of): c.

Due to (or as e consequence of): d.

Part II. **Other significant conditfons** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturaf 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier: ▶ Kim Schlageter

29c. License number: D-34868

29d. Date signed (Month, Day, Yeer): 06/03/2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Dr. Kim Schlageter 1105 T Little Patuxent Plz Columbia, MD 21044

State Registrar

31. Dete filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: ▶ Denise B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18405

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virgie V. Turnbaugh

2. Date of Death: Month JUNE Day 5, Year 2002

3. Time of Death: 1:50 AM M

4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-20-9690

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1910

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Phoenix

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14703 Carroll Road

10f. Zip Code: 21131

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert Emmett Minor

18. Mother's Name (First, Middle, Maiden Surname): Hattie E. Loy

19a. Informant's Name/Relationship (Type, Print): Betty Hannibal/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14206 Phoenix Ave. Phoenix, MD 21131

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens

Date: June 8, 2002

20c. Location - City or Town, State: Timonium, MD

21. Signature of Funeral Service Licensee: Michael J. Flagle

22. Name and Address of Facility: Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

ASPIRATION PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Alfonso

29c. License number: D 29306

29d. Date signed (Month, Day, Year): 6/5/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALFONSO ZALDUONDO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: Barbara B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK, TAGLIENTI
2. Date of Death: Month June Day 3rd Year 2002
3. Time of Death: 10:35 A M

4a. Facility Name (If not institution, give street and number): Northwest Hospital Cente
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 722-05-6349
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct.19,1928
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Owings Mills
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 10803 Meadowlea Road
10f. Zip Code: 21117
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1946-50
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): President
16b. Kind of Business/Industry: Haribou Candy Company

17. Father's Name (First, Middle, Last): Frank Taglienti
18. Mother's Name (First, Middle, Maiden Surname): Grace Martini

19a. Informant's Name/Relationship (Type, Print): Rosemary Weiss Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 41 South Ridgewood Avenue, South Orange, N.J. 07079

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Teresa's Cemetery
Date: June 7,2002
20c. Location - City or Town, State: Summit, New Jersey

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Loring Byers Funeral Directors,Inc. 8728 Liberty Road; Randallstown, Maryland 21133

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ADVANCED NON SMALL CELL CARCINOMA LUNG. — 4 YEARS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL TRANSPLANTATION RECEPIENT

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physicien**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ R Rangarajan M.D
29c. License number: D54288
29d. Date signed (Month, Day, Year): June 3rd 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAMASWAMY IRANGARAJAN NORTH WEST HOSPITAL CENTER

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

17th

Kevin Vines
Unknown 02-161
CJ
02-2791-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18407

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
KEVIN VINES	May	29	2002	08:06 A.M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5500 block Rubin Avenue	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-84-4874	1 X M 2 ☐ F	38 Yrs.					5-29-64	BALTIMORE, MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1 ☐ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5400 NELSON ST	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8TH GRADE		STOCK-CLERK	GROCERY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN	DELORES VINES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HARRY THOMAS step father	4724 WAKEFIELD RD APT-301 BALTO, MD 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	MT ZION CEMETERY	6-8-2002	BALTO, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Carlton C. Douglas	CARLTON C. DOUGLAS FUNERAL SERVICE P.A. 1701 MCCULLOH BALTO, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. TWO GUNSHOT WOUNDS OF CHEST	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	5/29/02	800 A M	1 ☐ Yes 2 X No	SUBJECT WAS SHOT BY POLICE
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
	STREET			5500 BLOCK RUBIN AVE, BALTIMORE, MD

29a. Certifier (Check only one) 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	May 29, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18408

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Anna W. Weil	June 4, 2002	4:05 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2926 Ayres Chapel Road	White Hall	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-22-0162	1 ☐ M 2 ☒ F	74 Yrs.			May 11, 1928	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	White Hall	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2926 Ayres Chapel Road	21161	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Manager	Automobile Leasing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown Weber	Christine Stepanek

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. David H. Weil/Husband	2926 Ayres Chapel Rd. White Hall, Md. 21161

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Dulaney Valley Mem. Grd.	6/8/02	Timonium, Maryland

21. Signature of Funeral Service Licensee: Michael J. Ruck

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PULMONARY HEMMORHAGE	INSTANT
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

LUNG CANCER

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
N Rosenblum MD	D 23319	JUNE 5 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NATHAN ROSENBLUM MD 7600 OSLER DRIVE TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18409

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie Watkins

2. Date of Death: Month JUNE Dey 6, Year 2002

3. Time of Death: 8:00 P.M.

4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE CROMWELL

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-34-1030

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/21/1906

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10e. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: PARKVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8528 CHESTNUT OAK ROAD

10f. Zip Code: 21234

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN

16b. Kind of Business/Industry: BALTIMORE COUNTY PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last): THOMAS FLETCHER

18. Mother's Name (First, Middle, Maiden Surname): ADDIE F. DANNER

19a. Informant's Name/Relationship (Type, Print): NELLIE M. SIBLEY DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8333 WYTON ROAD TOWSON, MD 21286

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): PARKWOOD CEMETERY

Date: 6/10/02

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Heather N. Sayes

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Failure to thrive

Due to (or as a consequence of):
b. Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atrial Fibrillation

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature end title of certifier

29c. License number: D41901

29d. Date signed (Month, Day, Year): 6-7-02

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print)
Ziad Mirza M.D. 3007 E. Northern PKWY. Balto. MD 21214

State Registrar

31. Dete filed (Month, Day, Year): JUN 07 2002

32. Registrer's Signature: Bonnie B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dale A. Weese Sr.	June 4 2002	9:30pm

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilcrest Center	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-46-2863	1☒M 2☐F	55 Yrs.			Feb.12 1947	WestVirginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Locetion	10d. Inside City Limits
MD	Baltimore	Middle River	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
108 Whistle Stop Road	21220	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Truck Driver	Maryland Messeager

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unknown	Mildred L. Weese

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MaryAnn Weese / wife	108 Whistle Stop Road Baltimore MD 21220

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bayview Crematory	6/7/02	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ R. Terry Connelly	ConnellyFuneralHomeofEssex 300 MAce Ave. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. tongue cancer	months
	Dua to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) hospice

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated. 2☐**Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Helen M. Gordon	D0051926	June 5, 2002

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Helen M. Gordon 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

@ 9:30 p.m. June 04, 2002 Dale Weese

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
CHARLES E. WEBSTER, JR	May 29, 2002	05:20 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-20-6772	1☑M 2☐F	15 Yrs.			10-06-1926	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6701 PARK HGTS. AVE.	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☑Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☑No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12TH GRADE	N/A	DOOR MAN	APARTMENT COMPLEX

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLES WEBSTER, SR	REGINA REDMAN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KAREN McMILLIAN	4229 LABYRINTH, BALTO. MD. 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	DRUID RIDGE CEME.	06-03-02	BALTO. MD

21. Signature of Funeral Service Licensee: Peter Wright Jordan M0015

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE, 5151 BALTO-NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined			1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ J. Morales, DO	RES-000	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jennifer A. Morales, Sinai Hospital of Baltimore, 2401 West Belvedere Avenue Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 07 2002	Regina G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18412

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy Ann Burow	MAY 22, 2002	17:26pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-16-2273	1☐M 2☒F	91 Yrs.			Oct. 26, 1910	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Garrett	Grantsville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
722 Miller Road	21536	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert Hampton Butler	Lottie Groves

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Glenna Gilpin, Daughter	4072 Maynardier Ridge Road, Grantsville, MD 21536

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Grantsville Cem., May	26, 2002	Grantsville, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ D Lynn Newman	Newman Funeral Homes, P.A. 179 Miller St., POBox 275, Grantsville, MD 21536

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	10 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE CEREBROVASCULAR ACCIDENT WITH RIGHT HEMIPARESIS

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ PHYSICIAN	D50844	MAY 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JOSE LOVERIA JR., MD 912 SETON DRIVE CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	▶

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18413

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GOLDIE A. BRITTINGHAM
2. Date of Death (Month, Day, Year): May 25, 2002
3. Time of Death: 10:05 AM

4a. Facility Name (If not institution, give street and number): Alice Byrd Tawes Nursing Home
4b. City, Town, or Location of Death: Crisfield
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 216-14-2239
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 28, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Marion Station
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 27479 Farm Market Road
10f. Zip Code: 21838
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk/Treasurer
16b. Kind of Business/Industry: Municipality

17. Father's Name (First, Middle, Last): Benjamin McCready
18. Mother's Name (First, Middle, Maiden Surname): Ida E. Adams

19a. Informant's Name/Relationship (Type, Print): John M. Brittingham, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26661 Old State Road - Crisfield, Maryland 21817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sunnyridge Memorial Park
Date: 5/29/02
20c. Location - City or Town, State: Crisfield, Maryland

21. Signature of Funeral Service Licensee: Mary Beth Bradshaw-Pruitt
Mary Beth Bradshaw-Pruitt
22. Name and Address of Facility: Bradshaw & Sons Funeral Home
306 W. Main Street - Crisfield, Maryland 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. ASCVD
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
RADIATION CYSTITIS

23b. Did tobecco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier
29c. License number: D 48098
29d. Date signed (Month, Dey, Yeer): 05/28/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18414

Floris Bunting 222-24-1303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
FLORIS KEEN BUNTING	May 16, 2002	1700

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-24-1303	1☐ M 2☒ F	85 Yrs.			11-24-1916	DELAWARE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DELAWARE	SUSSEX	DAGSBORO	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
RD#1 BOX 24A-6	19939	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		KITCHEN SUPERVISOR	HOSPITAL FOR THE MENTALLY RETARDED

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GEORGE G. KEEN	EVA A. KING

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FRANKLIN O. BUNTING/ SON	RT#1 BOX 15A, DAGSBORO, DELAWARE. 19939

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	DAGSBORO REDMENS MEMORIAL CEMETERY	5-21-02	DAGSBORO, DELAWARE

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MI	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. pericardial effusion	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CAD

HTN

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D0053394	5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony J. Frey, MD. 1315 S. Division Street Salisbury, MD 21801

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CM20

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	G. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18415

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN WAYNE BROWN
2. Date of Death (Month, Day, Year): May 27, 2002
3. Time of Death: 3:45 am

4a Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 219-80-4626
6. Sex: XX M 2☐ F
7. Age (In yrs. last birthday): 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JANUARY 27, 1959
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: CHARLES
10c. City, Town or Location: HILLTOP
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 7782 ANNAPOLIS WOOD ROAD
10f. Zip Code: 20646
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: XX 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER/DRIVER
16b. Kind of Business/Industry: TRANSPORTATION

17. Father's Name (First, Middle, Last): JAMES WILLIAM BROWN
18. Mother's Name (First, Middle, Maiden Surname): MARY REGINA DUNMORE HARRISON

19a. Informant's Name/Relationship (Type, Print): DORIS COOPER / SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8007 LAKETOWN COURT, SEVERN, MARYLAND 21144

20a. Method of Disposition: XX 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ST. CATHERINE'S CHURCH CEMETERY
Date: 6/1/2002
20c. Location - City or Town, State: MC CONCHIE, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson
LYDIA C. THORNTON JOHNSON MD0583
22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis of unknown source	hours
Due to (or as a consequence of): b.	Cirrhosis	months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Acute tubular necrosis	days
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A.N. Alikhani MD
29c. License number: D-0046046
29d. Date signed (Month, Day, Year): 5-27-02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mirza Alikhani, Amir A., PO Box 1890, LaPlata, MD 20646

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Benna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Brown, Melvin W.
Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours aftar daath with tha Maryland Dapartmant of Haalth and Mantal Hygiana.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquiras that tha daath cartificata be axecutad within 24 hours aftar daath.
To the Funeral Director: Aftar this cartificata has baan signed by tha attanding physician and compiataly fillad in by tha funaral diractor, paga 2 should ba datachad for usa as tha burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18416

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Doris Ann Beard	May 17 2002	1:00 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
39 Fitzhugh Avenue	Westminster	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-26-7897	1☐M 2☒F	72 Yrs.			July 25 1929	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Westminster	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
39 Fitzhugh Avenue	21157	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Howard Lockard	Edna Rogers

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Harry Beard, Jr./husband	39 Fitzhugh Avenue Westminster, MD 21157

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Sandymount Cemetery	May 20 2002	Finksburg, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John K Ady	Pritts Funeral Home and Chapel P.A. 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

None Known

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Howard Sowin, M.D.	Md. # D 15552	5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Sowin, M.D. 555 S. Center Street Westminster, Md. 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 5

CRW 7

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Dorothy Barnett

2. Date of Death: Month: May Day: 18 Year: 2002

3. Time of Death: 11:12am

4a Facility Name (If not institution, give street and number): Chapel Hill Nursing Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-28-0564

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 31, 1918

9. Birthplace (State or Foreign Country): NJ

Usual Residence of Decedent

10a. State: Md

10b. County: Carroll

10c. City, Town or Location: Marriottsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 6929 Cable Drive

10f. Zip Code: 21104

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Baltimore City Police

17. Father's Neme (First, Middle, Last): Russell Jones

18. Mother's Name (First, Middle, Maiden Sumame): Anna Waitts

19a. Informant's Name/Relationship (Type, Print): David C. Barnett (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6929 Cable Dr., Marriottsville, Md 21104

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 5-21-02

20c. Location - City or Town, State: Brentwood, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md. 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. ATHEROSCLEROTIC CEREBROVASCULAR

Due to (or as a consequence of): DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cauee of death?** 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law raquires that tha death certificate be executed within 24 hours aftar death.

To the Funeral Director: After this certificata has been signed by the attending physicien and completely filled in by tha funeral director, pege 2 should be detached for usa es the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ Tasneem Lakhani

29c. License number: D28595

29d. Date signed (Month, Dey, Yeer): 5/20/02

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD 21208

WJR 8

State Registrar

31. Dete filed (Month, Dey, Year): MAY 21 2002

32. Registrer's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18418

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy Lee Baker
2. Date of Death: Month May Day 20 Year 2002
3. Time of Death: 9:05 p M
4a. Facility Name (If not institution, give street and number): LongView Nursing Home
4b. City, Town, or Location of Death: Manchester
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 213-36-3005
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 24, 1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Hampstead
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1367 N. Main St. Apt. 1
10f. Zip Code: 21074
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: Maryland State Police

17. Father's Name (First, Middle, Last): Ira Thomas Holman Sr.
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Crabtree

19a. Informant's Name/Relationship (Type, Print): Cheryl Sherwood - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 747 Sportsman Ct. Hampstead, Md. 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LakeView Mem. Park
Date: May 23, 2002
20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Service Licensee: J. Heath Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Stroke — Approximate Interval Between Onset and Death: Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D33065
29d. Date signed (Month, Day, Year): 5/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Shaffer 2114 Hanover Pike Hampstead MD 21074

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: Geneva G Sparks

WJR 4

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2002 18419

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): JANNELL R. CINK

2. Date of Deeth: Month 5 Dey 23 Year 2002

3. Time of Death: 3:15 PM

4e Fecility Neme (If not institution, give street and number): 10 Serf Place

4b. City, Town, or Location of Deeth: Ocean Pines

4c. County of Deeth: Worcester

Funeral Director

5. Social Security Number: 220-12-6051

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan.23,1926

9. Birthplece (State or Foreign Country): VA

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Worcester

10c. City, Town or Location: Ocean Pines

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 10 Serf Place

10f. Zip Code: 21811

10g. Citizen of What Country? USA

11. Merital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Representative

16b. Kind of Business/Industry: Developer

17. Father's Name (First, Middle, Last): Joseph Alexander Sells

18. Mother's Name (First, Middle, Maiden Surname): Betty Rose (Not available)

19e. Informant's Name/Relationship (Type, Print): J. Norman Cink

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Serf Place, Ocean Pines, Md. 21811

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Cape Henlopen Crematory

Date: 5-24-02

20c. Location - City or Town, State: Frankford, Delaware

21. Signature of Funeral Service Licensee: Nancy M Henderson #000284

22. Name and Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Malignant Lymphoma — Approximate Interval: 8 months

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: MD

29c. License number: D26278

29d. Date signed (Month, Day, Year): 5-24-02

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): CM 6 DAVID E. COLLALL MD 143 E. Carroll St. Salisbury MD 21801

State Registrar

31. Dete filed (Month, Day, Year): MAY 24 2002

32. Registrer's Signature: Brenda B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that tha daath certificata be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18420

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Audrey Elizabeth Bolduc
2. Date of Death (Month, Day, Year): May 24, 2002
3. Time of Death: 9:00 AM
4a. Facility Name (If not institution, give street and number): 420 W Dares Beach Road, Apt. #211
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert Co.

Funeral Director

5. Social Security Number: 101-09-8206
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 14, 1918
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert Co.
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 420 W Dares Beach Road, Apt. #211
10f. Zip Code: 20678
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restraunt Owner
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Agustivo Egan
18. Mother's Name (First, Middle, Maiden Surname): Emily Palh

19a. Informant's Name/Relationship (Type, Print): George J. Bolduc (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3711 Meadow Beauty Drive, Pasco, Washington 99301

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lee Crematory
Date: May 27, 2002
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home Calvert, P.A. 20736
8125 Southern Maryland Blvd., Owings, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION — MINUTES
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. CORONARY ARTERY DISEASE — YEARS
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ATRIAL FIBRILLATION
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John H Weiger MD
29c. License number: D26358
29d. Date signed (Month, Day, Year): MAY 24, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN H. WEIGER, M.D. - PRINCE FREDERICK, MD - 20678

State Registrar

31. Date filed (Month, Day, Year): MAY 28 2002
32. Registrar's Signature: Geneva B Sparks

15

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18421

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William H. Dennis
2. Date of Death: Month: May Day: 22 Year: 2002
3. Time of Death: 2215 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-44-0818
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-19-47
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: md | 10b. County: Worcester | 10c. City, Town or Location: Pocomoke | 10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1920 Colona Road | 10f. Zip Code: 21851 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sold Fish
16b. Kind of Business/Industry: Ocean City Fish Co.

17. Father's Name (First, Middle, Last): Phillip Dennis Sr.
18. Mother's Name (First, Middle, Maiden Surname): Josephine Schoolfield

19a. Informant's Name/Relationship (Type, Print): Anna Turpin (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 Laurel Street Pocomoke md. 21851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. James Cemetary
Date: JUNE 1 2002
20c. Location - City or Town, State: Pocomoke MD

21. Signature of Funeral Service Licensee: [signature] for
22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 331 PO

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Liver Failure — Minutes
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. cirrhosis — Months
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
End-stage kidney Failure
Hepatitis C
HIV positive

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: 16725
29d. Date signed (Month, Day, Year): 5/23/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TAN, CONSTANTE 547-G Riverside Dr, Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

WILLIAM DENNIS #217-44-0818 5/30/02 2215 5740.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18422

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Carl Dorsey
2. Date of Death (Month, Day, Year): May 24, 2002
3. Time of Death: 4:10PM
4a. Facility Name *(If not institution, give street and number)*: Charlotte Hall Veterans Home
4b. City, Town, or Location of Death: Charlotte Hall
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 218-14-3785
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 27,1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Newburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12605 Shiloh Church Road
10f. Zip Code: 20664
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer
16b. Kind of Business/Industry: Farming

17. Father's Name *(First, Middle, Last)*: James Benjamin Dorsey
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Rebecca Wills Dorsey Thomas

19a. Informant's Name/Relationship *(Type, Print)*: Ollie Thomas/Sister
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: P.O. Box 1 Mt. Victoria,MD 20661

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other piece)*: Holy Ghost Cemetery — Date: 5/31/02
20c. Location - City or Town, State: Issue,MD

21. Signature of Funeral Service Licensee: David C. Echols — M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Carcinoma	4 yrs.
Due to (or as a consequence of):	b. Lung Carcinoma	4 yrs.
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of):	c. Emphysema	20 yrs.
Due to (or as a consequence of):	d. Pneumonia - Methicillin Resistant Staph. Aureus	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colonic polyps
Sigmoid diverticulitis
Benign Prostatic hypertrophy

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: Paul Stamis
29c. License number: D45092
29d. Date signed *(Month, Dey, Year)*: 5/24/02

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): 110 Hospital Road Suite 303 Prince Fredrick, MD 20678

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 29 2002
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours efter deeth.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, pege 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLIFTON NORWOOD DeVilbiss, JR.

2. Date of Death: Month MAY Day 18 Year 2002

3. Time of Death: 7:25PM

4e Facility Neme (If not institution, give street end number): CARROLL COUNTY General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 220-01-1924

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 6, 1915

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: CARROLL

10c. City, Town or Location: ELDERSBURG

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6213 Longmeadow Drive Apt. A

10f. Zip Code: 21784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943 - 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security GUARD

16b. Kind of Business/Industry: GENSTAR

17. Father's Name (First, Middle, Last): Dr. Clifton N. DeVilbiss, SR.

18. Mother's Name (First, Middle, Maiden Sumame): Adelaide Hoffman

19a. Informant's Name/Relationship (Type, Print): MURIEL D. DeVilbiss / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6213 Longmeadow Dr Eldersburg MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Pipe Creek Cemetery

Date: 5/22/02

20c. Location - City or Town, State: New Windsor, MD

21. Signature of Funeral Service Licensee: Jeff N. Zumbrun

22. Name and Address of Facility: ZUMBRUN F.H. & MON. CO. 6028 Sykesville Road Eldersburg MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Severe ASCVD — Approximate Interval: 25yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and ptace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Middleton

29c. License number: D25443

29d. Date signed (Month, Dey, Year): 5/20/02

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John W. Middleton 688 Poole Road, Westminster Md 21157

State Registrar

31. Date filed (Month, Day, Year): MAY 21 2002

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mantel Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJL 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2002 18424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ANNABELLE ENT	5 / 19 / 2002	1116 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-30-1405	1 ☐ M 2 ☒ F	72 Yrs.			September 30, 1929	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Somerset	Dames Quarter	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
24454 Hideaway Lane	21821	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Homemaker	At Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clifford Bozman	Mary Jones

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles D. Ent (Husband)	24454 Hideaway Lane - Dames Quarter, MD 21821

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	White Cemetery	5/22/02	Dames Quarter, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Mary Beth Bradshaw-Pruitt Mary Beth Bradshaw-Pruitt	Bradshaw & Sons Funeral Home 306 W. Main Street - Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Closed head injury	45min
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HTN

Alzheimers

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
5/19/02	1000 AM	1 ☐ Yes 2 ☒ No	Fell off steps

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Daughters house	1609 S. Kingwood Ave. Salisbury MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ DME	H50497	5/20/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Christopher Snyder MD. 100 E Carroll St. Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	▶ Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Annabelle Ent

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Edward Francis Ensley Jr.	4/29/02	20:07 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-80-5441	1 [X] M 2 [ ] F	31 Yrs.			April 17,1971	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Wicomico	Salisbury	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
926 Snow Hill Road	21802	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0		Disabled	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Edward Francis Ensley Sr.	Peggy Ann Collins

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ginger Truax sister	25430 Smith Landing Rd Denton,MD 21629

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Greensboro Cemetery	May 2,2002	Greensboro,Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Hope C Fleegle	Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Dead bowel (95%)	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): b.	small bowel obstruction	
Due to (or as a consequence of): c.	Adhesions	
Due to (or as a consequence of): d.		

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Michael D Sofranski	D52198	4/29/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MICHAEL SOFRANSKI 100 E CARROLL ST. SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY - 2 2002	▶ Rebecca G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ENSLEY, EDWARD SS#215-80-5441 4/29/02 4007 23A CARROLL-2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18426

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RONALD ELVIN FLEMING	MAY 28, 2002	1:16 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SOUTHERN MARYLAND HOSPITAL	CLINTON	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-74-8171	1 X M 2 F	48 Yrs.					JULY 10, 1953	WASHINGTON, D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGES	TEMPLE HILLS	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5301 CORKRAN LANE	20748	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 Widowed 4 X Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	SHIPMENT RECEIVER	RETAIL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HENRY FLEMING	ELSIE ELEANOR DIGGS FLEMING

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
THERESA FLEMING/SISTER	5301 CORKRAN LANE TEMPLE HILLS, MARYLAND 20748

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	RESURRECTION CEMETERY	06/01/2002	CLINTON, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
LYDIA C. THORNTON JOHNSON	THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RENAL FAILURE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): HIV	
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) _____ 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Nah Mthr MO	D52289	05/28/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
NALIN MATHUR, 10 ST. PATRICK'S DRIVE, SUITE 404, WALDORF, MD 20603

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	B. Spencer

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18427

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert George Fehle Sr.

2. Dete of Death Month: May Dey: 22 Year: 2002

3. Time of Death: 6:30am

4e Feclity Neme *(If not institution, give street and number)*: 1848 Jordans Retreat Road

4b. City, Town, or Location of Death: New Windsor

4c. County of Deeth: Carroll

Funeral Director

5. Social Security Number: 212-30-2388

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 9 1927

9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md

10b. County: Carroll

10c. City, Town or Location: New Windsor

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1848 Jordans Retreat Road

10f. Zip Code: 21776

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Merried 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1945-1948

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: steamfitter

16b. Kind of Business/Industry: pipefitting

17. Father's Neme *(First, Middle, Last)*: Charles Robert Fehle

18. Mother's Name *(First, Middle, Maiden Surname)*: Henrietta Braunschmidt

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Joan Fehle (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1848 Jordans Retreat Rd., New Windsor, Md 21776

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Evergreen Memorial

Date: 5-25-02

20c. Location - City or Town, State: Finksburg, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Cardiomyopathy — 14yr

Due to (or es a consequence of):

b. ASCVD — 25y

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Due to (or as e consequence of):

c. Diabetes — 15y

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ John W. Middleton

29c. License number: D25443

29d. Date signed *(Month, Day, Year)*: 5/23/02

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): John W. Middleton 688 Poole Road, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Dey, Year)*: MAY 23 2002

32. Registrer's Signeture: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pegas 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificete be executed within 24 hours after deeth.
To the Funeral Director: After this cartificete has been signed by the attanding physician and completely filled in by tha funaral director, page 2 should be datached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CEW 12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No: 2002 18428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Pearl Helen Garlitz	MAY 22, 2002	21:55PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sacred Heart Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-14-5577	1☐M 2☒F	79 Yrs.					Jan 13, 1923	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Garrett	Lonaconing	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
259 Sam Crow Road	21539	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8 th		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Noah McKenzie	Inez Minick

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Miles J. Garlitz/son	259 Sam Crow Rd., Lonaconing, MD 21539

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MD State Veteran's Cem	May 28,02	Flintstone, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Newman Funeral Homes, P.A., PO Box 275
~~179 Miller St., Grantsville, MD 21536~~

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR INFARCTION — 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) ____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DIABETES MELLITUS
DIABETIC RENAL DISEASE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA

26. Place of Death (Check only one)
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert Welk	D31675	MAY 23, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR ROBERT WELK, 902 SETON DRIVE, #308, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2002 18429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Lest): Arlene (NMI) Geczi

2. Date of Deeth: Month May Dey 26, Year 2002

3. Time of Death: 3:40PM

4a Fecility Neme (If not institution, give street end number): 30650 Heather Glen Dr.,

4b. City, Town, or Location of Deeth: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Sociel Security Number: 155-22-6786

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 71 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Aug. 19, 1930

9. Birthplace (State or Foreign Country): N.J.

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Worcester

10c. City, Town or Location: Ocean Pines

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 7611 Yacht Club Drive

10f. Zip Code: 21811

10g. Citizen of What Country?: US

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 2; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Teachers Assistant

16b. Kind of Business/Industry: Public School

17. Father's Neme (First, Middle, Last): Louis Perrochino

18. Mother's Name (First, Middle, Maiden Surname): Anna Pittoria

19a. Informant's Name/Relationship (Type, Print): Robert Geczi

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 7611 Yacht Club Dr., Berlin, Md. 21811

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cape Henlopen Crematory

Date: 5-30-02

20c. Location - City or Town, State: Frankford, Delaware

21. Signeture of Funeral Service Licensee: James D Henderson 100284

22. Neme end Address of Facility: The Burbage Funeral Home, 108 William St., Berlin, Md. 21811

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or kidney failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death) a. Multiple Myeloma — 4 1/2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Home of Daughter

27. Menner of Death: 1☒ Nature 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number: D20507

29d. Date signed (Month, Day, Year): 5/28/02

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Joseph A Grasso 145 E Carroll St Salisbury MD

ET 6o

State Registrar

31. Date filed (Month, Day, Year): MAY 28 2002

32. Registrer's Signeture

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Heelth end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be executed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end

DHMH 16 Rev 6/95

ORIGINAL

02-2589-047
Kathi Ann Glagola
crh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPEND ITEMS #23a &27 per me. g809 7/25/02 JH

Certificate of Death

Reg. No. 2002 18430

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
KATHI	ANN	GLAGOLA	May	18	2002	8:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1510 Linden Drive	Pocomoke City	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
147-50-6757	1☐ M 2☒ F	47 Yrs.			May 28, 1954	Kentucky

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Worcester	Pocomoke City	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1510 Linden Drive	21851	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Lab Technician	Medical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Palmer	Nancy Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward C. Glagola (husband)	1510 Linden Drive, Pocomoke City, MD 21851

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	First Baptist Cemetery	May 22, 2002	Pocomoke City, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael A Dean M01129	Holloway Melson Funeral Home, P.A. 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GLIOMA of the BRAIN	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	May 19, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 23 2002	▶ G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18431

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Paul Charles Groot	May 25, 2002	5:05 AM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Calvert Memorial Hospital	Prince Frederick	Calvert County

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
571-34-8239	1☒ M 2☐ F	71 Yrs.			April 19, 1931	California

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Calvert Co.	Sunderland	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5761 Highland Lane	20689	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1952 1954	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+4	Engineer	Aerospace Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Carl B. Groot	Elizabeth Mae Ensign

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michele Lynn Groot (Wife)	1947 Oriole Way, St. Leonard, Maryland 20685

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lee Crematory	May 27, 2002	Clinton, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Lee Funeral Home Calvert, P.A. 20736 8125 Southern Maryland Blvd., Owings, Maryland

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic Neck Cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alcohol Abuse

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D37588	5/26/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RAFIK A-NASR-MD, 135 W. Dares Beach Rd, Prince Frederick MD 20678

25+1

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	▶ Jenna G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrar

Certificate of Death

Reg. No. 2002 | 8432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gilbert Leroy Gardner, Sr.	May 15, 2002	11pm M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Continuum Care at Sykesville	Sykesville	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220 05 7648	1☒M 2☐F	84 Yrs.			July 1, 1917	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Carroll	Sykesville	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
805 Old Liberty Road	21784	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	+1	Textile Executive	Textile

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Allyn A. Gardner	Caroline Moore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Gilbert L. Gardner, Jr. (Son)	805 Old Liberty Road Sykesville, Md. 21784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Wesley Freedom Cemetery	5/18/02	Sykesville, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Harry W. Haight	Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

b. C.H.F

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HTN

Due to (or as a consequence of):

d. C.V.A

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anaemia
Seizure disorder
GOUT

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown	
24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
RM Ocampo MD	D-0054218	05-16-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Roman B. Kanena, 419-F Malcolm drive, Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	Jenna G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 15

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Corbin Hall

2. Date of Death: Month 5 Day 18 Year 2002

3. Time of Death: 1230 M

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-16-7806

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 11, 1914

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Princess Anne

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 32690 ED Boston RD

10f. Zip Code: 21853

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER

16b. Kind of Business/Industry: Housewife

17. Father's Name (First, Middle, Last): LEVI Corbin

18. Mother's Name (First, Middle, Maiden Surname): CARRIE Doane

19a. Informant's Name/Relationship (Type, Print): Viola F. Mason - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10124 Campus Way South Upper Marlboro, MD 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. MARK'S Cemetery

Date: 05-23-02

20c. Location - City or Town, State: Oaksville, MD

21. Signature of Funeral Service Licensee: Anthony E. Ward

22. Name and Address of Facility: Anthony E. Ward Funeral Home 30639 Hampden Ave. Princess Anne, MD 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular Disease — 2 years.

Due to (or as a consequence of):

b. Diabetes mellitus. — 10 years

Due to (or as a consequence of):

c. Aortic Stenosis — 2 year

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case relerred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Usha Natesan

29c. License number: D051359

29d. Date signed (Month, Day, Year): May 20th 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 106 Pine Bluff Road, Salisbury, MD 21801. USHA NATESAN, M.D.

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dorothy Hall 212 16 7806

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend date 1- For State Registrar per f.h., bg, 5/29/02 — *Certificate of Death* — Reg. No. 2002 18434

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beatrice B. Harrison

2. Date of Death: Month 05 Day 23 Year 02

3. Time of Death: 0220 M

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-09-0994

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-4-15

9. Birthplace (State or Foreign Country): Minnesota

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Deal Island

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 10220 Hotel Road

10f. Zip Code: 21821

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): none

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Benjamin Bassett

18. Mother's Name (First, Middle, Maiden Surname): Adeline Bassett

19a. Informant's Name/Relationship (Type, Print): Beatrice Daniels/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9213 Deal Island Road, Wenona, MD 21821

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Johns U.M. Cemetery

Date: 05/25/02

20c. Location - City or Town, State: Deal Island, MD

21. Signature of Funeral Service Licensee: James E. Hinman M00295

22. Name and Address of Facility: Hinman Funeral Home, 11673 Somerset Ave., Princess Anne, MD 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardio Vascular Ds.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death: 40 yrs.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
HyperLipidemia
Myocardial Infarction

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D24986

29d. Date signed (Month, Day, Year): 5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert J. Reilly MD 560 Riverside Dr. Salisbury Md. 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

BEATRICE HARRISON #220-09-0994 864 5/28/02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ANDREA LEE HAIGLEY	May 26, 2002	1830 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-38-0699	1 ☐ M 2 ☒ F	60 Yrs.			4-30-42	MD.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	WORCESTER	BERLIN	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
12327 SINEPUXENT ROAD	21811	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		MANAGER	HOSPITALITY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
VINCENT J. FLORENTINE	MARY H. BEATY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ARDEN V. HAIGLEY SON	2036 ORCA CT., FERNANDINA BEACH, FL., 32034

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	SALISBURY CREMATORY	5-27	SALISBURY, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
[signature]	ULLRICH FUNERAL HOME BERLIN, MD.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CVA	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): (L) Subclavian thrombosis / Arm ischemia	10 days
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ulcerative colitis

23e. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
David C. Kerrigan, MD	44688	05/27/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David C. Kerrigan, MD, 560 Riverside Dr., Suite A206, Salisbury, MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

212-38-0699

Andrea Haigley

ET 6

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Cora Elizabeth Hutchins	May 27, 2002	12:17PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
982 Curtis Road	Dowell	Calvert

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-28-1932	1☐M 2☒F	89 Yrs.			Aug. 12, 1912	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	Dowell	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
982 Curtis Road	20629	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Augustus Curtis	Mary Etta Watts

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paul D. Hutchins, Sr./Son	326 Baltimore St. Aberdeen, MD 21001

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	St. John UMC Cemetery	5/31/02	Lusby, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys A. Sewell	Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Diabetes — 10 years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Charles W. Bennett M.D.	D25156	May 28, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Charles W. Bennett M.D., 11845 Trueman Rd., Lusby, Md. 20657

6

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18437

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William Allen Hicks

2. Dete of Death Month: MAY Day: 21 Year: 2002

3. Time of Death: 11:05 AM

4e. Feciity Neme (If not institution, give street end number): 1105 Dares Beach Road

4b. City, Town, or Location of Deeth: Prince Frederick

4c. County of Deeth: Calvert

Funeral Director

5. Social Security Number: 218-42-0696

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthday): 59 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 30, 1943

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Prince Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1105 Dares Beach Road

10f. Zip Code: 20678

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1968-1970

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Edeution (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Railroad Inspector

16b. Kind of Business/Industry: Railroad Company

17. Fether's Neme (First, Middle, Last): Lawrence Hicks

18. Mother's Name (First, Middle, Maiden Surname): Mildred Young

19a. Informant's Name/Reletionship (Type, Print): Patricia Hicks/wife

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 1105 Dares Beach Rd. Prince Frederick, MD 20678

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cheltenham Veterans Cem. Date: 5/29/02

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Blades A. Sewell

22. Name and Address of Feciity: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic Cardiovascular Heart Disease

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as steted. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Salvador Silvestry MD

29c. License number: H005927

29d. Date signed (Month, Day, Yeer): MAY 22 2002

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Salvador Silvestry 3001 Hospital Drive Cheverly, Maryland 20785

5+1

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002

32. Registrer's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18438

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SARAH SPURRIER JENNESS HICKS

2. Date of Death (Month, Day, Year): MAY 16, 2002

3. Time of Death: 1:37 PM

4a. Facility Name *(If not institution, give street and number)*: CARROLL LUTHERAN VILLAGE HEALTHCARE CENTER

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 219-42-2055

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOVEMBER 29,1904

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: WESTMINSTER

10d. Inside City Limits: 1☐ Yes XX No

10e. Street and Number: 761 WINCHESTER DRIVE

10f. Zip Code: 21157

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name *(First, Middle, Last)*: ROBERT EMORY SPURRIER

18. Mother's Name *(First, Middle, Maiden Surname)*: MOLLIE BUXTON

19a. Informant's Name/Relationship *(Type, Print)*: WILLIAM JENNESS/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 761 WINCHESTER DRIVE, WESTMINSTER, MD 21157

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MEADOW BRANCH CEMETERY

Date: 5/21/02

20c. Location - City or Town, State: WESTMINSTER, MARYLAND

21. Signature of Funeral Service Licensee: Robert A. Myers

22. Name and Address of Facility: MYERS FUNERAL HOME 91 WILLIS STREET WESTMINSTER, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Advanced Dementia, Neurogenic Bladder

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner.** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D37949

29d. Date signed *(Month, Day, Year)*: May 16th 2002

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): Alexander Brodaschewsky 295 Seven Ave, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 2002

32. Registrar's Signature: Donna D Sparks

WJL 8

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Georgia Ernestine Holland	April 12 2002	0445A[M]

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Atlantic General Hospital	Berlin	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
156-16-7950	1☐M 2☒F	100 Yrs.			Sept. 3, 1901	New Jersey

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Cape May	Cape May Court House	☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
Pierce's Point	08210	US

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Temmler	Ernestine Diem

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mark A. Teaney, III	403 Ocean Parkway, Ocean Pines, Md. 21811

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	George Washington Memorial Park	4/16/02	Paramus, New Jersey

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ W. Bird Burbage	The Burbage Funeral Home 108 William St., Berlin, Md. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bowel obstruction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☑No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☐Probably 4☑Unknown	1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0054997	4/12/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Michael P. Darnell, M.D. 29 Broad St., Suite 201, Berlin, Md. 21811

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 15 2002	▶ G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HOLLAND, GEORGIA 10dyF
156167950 0445 4/12/02

Work 23A

ET 2

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Benjamin Bowling Kemp
2. Date of Death: Month May Day 24 Year 2002
3. Time of Death: 8:18PM
4a. Facility Name (If not institution, give street and number): 6755 Poynton Manor Farm Place
4b. City, Town, or Location of Death: Welcome
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 217-18-2403
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 9,1926
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Welcome
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 6755 Poynton Manor Farm Place
10f. Zip Code: 20693
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farming

17. Father's Name (First, Middle, Last): Salvadore Worthington Kemp
18. Mother's Name (First, Middle, Maiden Surname): Catherine Wills

19a. Informant's Name/Relationship (Type, Print): David Kemp/Son
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 6280 Valley Rd. La Plata,MD 20646

20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): St. Ignatius Cemetery | Date: 5/30/02
20c. Location - City or Town, State: Port Tobacco,MD.

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,P.A. P.O. BOX 567 LA PLATA,MD. 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer
Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier:
29c. License number: D44436
29d. Date signed (Month, Dey, Year): May 28, 2002

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Ashvinkumar J. Patel 102 Paul Mellon Court #102 Waldorf, Maryland 20601

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Lenora G. Spencer

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 1844

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annie Laurine Moore

2. Date of Death: Month May Day 22 Year 2002

3. Time of Death: 0811 AM

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 463-34-9495

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-6-23

9. Birthplace (State or Foreign Country): Brookshire, Texas

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 406 Punkin Court

10f. Zip Code: 21804

10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nursing Assistant

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): Willie Moore

18. Mother's Name (First, Middle, Maiden Surname): Beatrice Logan

19a. Informant's Name/Relationship (Type, Print): Mildred Davis - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 Punkin Court Salisbury, MD 21804

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory

Date: 5-24-2

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Anthony E. Ward

22. Name and Address of Facility: Anthony E. Ward Funeral Home 30639 Hampden Ave. Princess Anne, MD 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: H50497

29d. Date signed (Month, Day, Year): 5/22/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRIS SNYDER 100 E. CARROLL ST. SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002

32. Registrar's Signature: Penny B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

900 - 26 - 9571

Annie Moore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IDA LEE MARTIN
2. Date of Death: Month May Day 21 Year 2002
3. Time of Death: 1705 M
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-26-3520
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 8, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Crisfield
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 104 Somers Cove Apartments
10f. Zip Code: 21817
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Co-Owner
16b. Kind of Business/Industry: Taxi Cab Company

17. Father's Name (First, Middle, Last): Herman Walston
18. Mother's Name (First, Middle, Maiden Surname): Mamie Somers

19a. Informant's Name/Relationship (Type, Print): Linda S. Mister (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Columbia Avenue - Crisfield, Maryland 21817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): VFW Memorial Cemetery
Date: 5/24/02
20c. Location - City or Town, State: Crisfield, Maryland

21. Signature of Funeral Service Licensee: Mary Beth Bradshaw-Pruitt
Mary Beth Bradshaw-Pruitt
22. Name and Address of Facility: Bradshaw & Sons Funeral Home
306 W. Main Street - Crisfield, Maryland 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CarDiogenic Shock — min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. myocardial ischemia — days
Due to (or as a consequence of):
c. CVD — 3 yr
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Raffetto
29c. License number: D 20444
29d. Date signed (Month, Day, Year): 5-21-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Raffetto M.D. 400 Eastern Shore Drive, Salisbury MD. 21804

State Registrar

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: Penny G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

220-26-3520

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Ida Martin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ERNEST MARVEL	MAY 22 2002	8-30A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOWARD COUNTY GENERAL HOSPITAL	COLUMBIA	HOWARD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
221-40-4649	1☒M 2☐F	48 Yrs.					9-6-1953	DELAWARE

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
DELAWARE	SUSSEX	FRANKFORD	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
RD#1 BOX 188	19945	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SALESMAN	AUTOMOBILE DEALERSHIP

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ERNEST B. MARVEL	SARAH MITCHELL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BRYAN J. MARVEL/ SON	RD#1 BOX 4-HA, FRANKFORD, DELAWARE. 19945

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MILLSBORO CEMETERY	5-25-02	MILLSBORO, DELAWARE

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: MELSON FUNERAL SERVICES, LTD. 43 THATCHER STREET, FRANKFORD, DELAWARE. 19945

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ANOXIC ENCEPHALOPATHY	DAYS
Due to (or as a consequence of):	b. RESPIRATORY FAILURE	DAYS
Due to (or as a consequence of):	c. END STAGE RENAL DISEASE	MONTHS
Due to (or as a consequence of):	d. UROSEPSIS	DAYS

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ SHAPIRO MD	D0053150	MAY 22 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHAKUNTALA GUPTA 201-109 BACK RIVER NECK RD BALTIMORE 21221

CM 6

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18444

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlotte Michaels
2. Date of Death Month / Day / Year: MAY 22, 2002
3. Time of Death: 4" pm
4a. Facility Name *(If not institution, give street and number)*: NORTHWEST HOSPITAL CENTER 5401 old Court Rd
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-05-2190
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9/9/1916
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 19E WASHINGTON LANE
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BEAUTICIAN
16b. Kind of Business/Industry: BEAUTY SALON

17. Father's Name *(First, Middle, Last)*: WILMER JOHN HOOVER
18. Mother's Name *(First, Middle, Maiden Surname)*: LYDIA MELVA BROWN

19a. Informant's Name/Relationship *(Type, Print)*: Son WILLIAM L. SHAFFER, JR.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 19E WASHINGTON LANE, WESTMINSTER, MD. 21157

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ALL COUNTY CREMATION
Date: 5/24/02
20c. Location - City or Town, State: SYKESVILLE, MD.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST.,WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Alzheimers Disease
Due to (or as a consequence of):
b. Congestive Heart Failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Osteoporosis
Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert B Kroopnick
29c. License number: 01453
29d. Date signed *(Month, Day, Year)*: 5/23/02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert B. Kroopnick, M.D. 4000 Old Court Road Pikesville, Maryland 21208

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 23 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WJR 3

Amend Item 23a Part I, b per Physician 05/22/2002 Carroll County, wjl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18445

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James R. Milani, Sr.
2. Date of Death Month: May Day: 18 Year: 2002
3. Time of Death: 1207 PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 215-24-0580
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 24, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 947B Lorimel Road
10f. Zip Code: 21784
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Financial

17. Father's Name (First, Middle, Last): Frank Milani
18. Mother's Name (First, Middle, Maiden Surname): Mary Regan

19a. Informant's Name/Relationship (Type, Print): Mr. Mark V. Milani (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8363 Capel Drive, Pasadena, MD 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: 5/22/02
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Brian L. Haight
22. Name and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hemorrhage — one day
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. AORTIC ABDOMINAL ANEURYSM — one day
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
~~Aortic abdominal Aneurysm~~, Coronary artery disease, Hypertension, Diabetes

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: B Rothman
29c. License number: RES-000
29d. Date signed (Month, Day, Year): May 18, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brian Rothman 600 North Wolfe Street Baltimore, Maryland 21287-9106

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002
32. Registrar's Signature: Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18446

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHYLLIS ELIZABETH PACHECO
2. Dete of Deeth Month MAY Dey 22, Year 2002
3. Time of Death: 1:35 PM
4e Feciity Name (If not institution, give street and number): GARRETT COUNTY MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: OAKLAND
4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 185-18-6650
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 15, 1924
9. Birthplace (State or Foreign Country): PA

Usuel Residence of Decedent

10a. State: MD
10b. County: GARRETT
10c. City, Town or Location: OAKLAND
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 623 S. THIRD STREET
10f. Zip Code: 21550
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12) / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REGISTERED NURSE
16b. Kind of Business/Industry: NURSING

17. Father's Neme (First, Middle, Last): PHILLIP CHASE MOORE
18. Mother's Name (First, Middle, Maiden Surname): CLARA FEHL

19a. Informant's Name/Relationship (Type, Print): CARLOS PACHECO - HUSBAND
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 623 S. THIRD STREET OAKLAND, MD 21550

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): OMEGA CREMATORY
Date: 5/24/02
20c. Location - City or Town, State: MORGANTOWN, WV

21. Signature of Funeral Service Licensee: Robert M Durst M00167
22. Name and Address of Facility: P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS
Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cauee of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.
29b. Signature end title of certifier: Donald Richter M.D.
29c. License number: D0030035
29d. Date signed (Month, Dey, Year): 5/24/02

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DONALD R. RICHTER, M.D. 1533 MEMORIAL DRIVE OAKLAND, MD 21550

State Registrar

31. Dete filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature: Jeanne D Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylend Department of Health end Mentel Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter deeth.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Pepper
2. Date of Death (Month, Day, Year): May 24, 2002
3. Time of Death: 11:37 PM
4a. Facility Name (If not institution, give street and number): 27605 Fitzgerald Road
4b. City, Town, or Location of Death: Princess Anne
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 155-16-8661
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11/02/1922
9. Birthplace (State or Foreign Country): Scotland

Usual Residence of Decedent

10a. State: MD
10b. County: Somerset
10c. City, Town, or Location: Princess Anne
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 27605 Fitzgerald Road
10f. Zip Code: 21853
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): none
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James McAllister
18. Mother's Name (First, Middle, Maiden Surname): Jane Miller

19a. Informant's Name/Relationship (Type, Print): Barbara Zaczkiewicz/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27605 Fitzgerald Road, Princess Anne, MD 21853

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Salisbury Crematory
Date: 05/28/02
20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: James L. Hinman MO0295
22. Name and Address of Facility: Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic breast cancer — 8 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Stegman MD
29c. License number: D25219
29d. Date signed (Month, Day, Year): 5-28-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Stegman, M.D. Mt. Vernon Road, Princess Anne, MD 21853

State Registrar

31. Date filed (Month, Day, Year): MAY 29 2002
32. Registrar's Signature: Brenda B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrer

Certificate of Death

Reg. No: 2002 18448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
JoAnn Marie Pagliaro	May 25, 2002	9:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2520 Kings Landing Road	Huntingtown	Calvert Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
233-66-8949	1 ☐ M 2 ☒ F	59 Yrs.			July 17, 1942	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Calvert Co.	Huntingtown	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2520 Kings Landing Road	20639	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	+1	Cosmetologist	Self-Employed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Albert Lechiara	Yolanda Pellegrino

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joanna Jo Pagliaro Gott (Daughter)	2520 Kings Landing Rd., Huntingtown, MD 20639

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Resurrection Cemetery	May 30, 2002	Clinton, Maryland

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: Lee Funeral Home Calvert, P.A. 20736, 8125 Southern Maryland Blvd., Owings, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. carcinomatous meningitis	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. breast cancer	22 years
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D 56024	May 28 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Kenneth L. Abbott 110 Hospital Road Suite 110 Prince Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

DHMH 17 Rev 1/2001

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Hortense Marie Parr	May 20, 2002	3:05am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
551-34-5967	1☐ M 2☐ F	77 Yrs.			June 15, 1925	Kansas

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	College Park	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9217 Wofford Lane	20740	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	3	Homemaker	Homemaker

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Iver Nelson	Lula Hambee

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nicholas Parr, son	962 Golden West Way, Lusby, Maryland 20657

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Southern Memorial Gardens	5/27/02	Dunkirk, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ G. Wood	Raymond-Wood Funeral Home P.O. Box 430, Dunkirk, Maryland 20754

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CARDIOPULMONARY ARREST	
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	b. ACUTE MYOCARDIAL INFARCTION	
	Due to (or es e consequence of):	
	c. CEREBROVASCULAR ACCIDENT	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause ot deeth?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was cese referred to medical examiner?	26. Plece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) end manner es stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Onyeaka MD	D46529	MAY 20 2002

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)
VICTOR ONYEAKA - 7325A HANOVER PARKWAY GREENBELT MARYLAND 20770

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
MAY 24 2002	▶ G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law raquiras that tha daath cartificata ba axecutad within 24 hours aftar daath.
To the Funeral Director: Aftar this cartificata has baen signed by tha attanding physician and compliataly filled in by tha funaral diractor, paga 2 should ba datachad for usa as tha burial-transit permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

02-2521-045
B.K.S
JASON PALACULCA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Jason Douglas Palacorolla	MAY 14, 2002	1200P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-06-4013	1☒ M 2☐ F	17 Yrs.			Aug 19 1984	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Carroll	Union Bridge	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3545 Middleburg Road	21791	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Student	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles Rahe Palacorolla Sr	Jane Rapp

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Charles Palacorolla Sr/father	3545 Middleburg Road Union Bridge, MD 21791

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Paul's Cemetery	5/18/2002	Uniontown, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
Pritts Funeral Home and Chapel
412 Washington Road Westminster, MD 21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gunshot wound to the head	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☑ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	5-14-02	0610 AM	1☐ Yes 2☑ No	Deceased shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
car outside hospital	PRMC ER. parking lot

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	O.C.M.E	MAY 16, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 20 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18451

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emma Catherine RUMER
2. Date of Death Month Day Year: 5-19-02
3. Time of Death: 12:12 AM
4a. Facility Name (If not institution, give street and number): 793 Crellin-Underwood Road
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 219-44-0676
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-26-1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Oakland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 793 Crellin-Underwood Road
10f. Zip Code: 21550
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Jacob ----- Nair
18. Mother's Name (First, Middle, Maiden Surname): Mary ----- Smith

19a. Informant's Name/Relationship (Type, Print): Daniel Rumer/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 651 Crellin-Underwood Rd., Oakland, MD 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oakland Cemetery
Date: 5/21/02
20c. Location - City or Town, State: Oakland, Maryland

21. Signature of Funeral Service Licensee: Bradley A. Stewart
22. Name and Address of Facility: Stewart Funeral Home 32 S. Second St., Oakland, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — 1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Diabetes Mellitus Type II — 20 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension, Dementia

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Margaret A. Kaiser
29c. License number: D26650
29d. Date signed (Month, Day, Year): 5-24-02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margaret A. Kaiser MD 13079 Garrett Highway Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year): MAY 24 2002
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

02-2851-013
DENISE F. ROSEWAG
AKT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEMS#27,28d per ME G808 062502 ss UNPENDED 061302:ITEMS#23a,27,28a-f per ME G808 ss

Certificate of Death

Reg. No. 2002 18452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Denise Farace Rosewag

2. Date of Death: Month MAY Day 30 Year 2002

3. Time of Death: 7:05P M

4a. Facility Name (If not institution, give street and number): 903 LOBLOLLY PINE CT

4b. City, Town, or Location of Death: SYKESVILLE

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 219-80-8370

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 5 1961

9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 903 Loblolly Pine Court

10f. Zip Code: 21784

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): executive secretary

16b. Kind of Business/Industry: health care

17. Father's Name (First, Middle, Last): Samuel Joseph Farace Sr.

18. Mother's Name (First, Middle, Maiden Surname): Diane Campbell

19a. Informant's Name/Relationship (Type, Print): Gary L. Rosewag Sr. (spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 903 Loblolly Pine Ct., Sykesville, Md 21784

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) entombment

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Memorial

Date: 6-4-02

20c. Location - City or Town, State: Sykesville, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

26. Place of Death (Check only one) Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) ON SCENE

27. Manner of Death: 1☐Natural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigation ~~6☒Could not be~~ determined

28a. Date of Injury (Month, Day Year): 5-30-02

28b. Time of Injury: Found: 6:50 P M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: ~~Unknown~~ Subject ingested narcotics

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found: residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 903 Loblolly Pine Ct., Sykesville, Carroll County, MD

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MAY 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 04 2002

32. Registrar's Signature: ▶ Geneva B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJR 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALICE REBECCA SPOERLEIN
2. Date of Death (Month, Day, Year): MAY 20, 2002
3. Time of Death: 10:15 PM
4e. Facility Neme (If not institution, give street and number): 137 HILLSIDE DRIVE
4b. City, Town, or Location of Deeth: OAKLAND
4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 213-64-9295
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 92 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC 4, 1909
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: GARRETT
10c. City, Town or Location: OAKLAND
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 137 HILLSIDE DRIVE
10f. Zip Code: 21550
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): LAWRENCE FRANKLYN TUCKER
18. Mother's Name (First, Middle, Maiden Sumame): HARRIET ZULIME RAINEY

19a. Informant's Name/Relationship (Type, Print): CAROLYN UPDYKE - DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 624 S. THIRD ST. OAKLAND, MARYLAND 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRETT MEMORIAL GARDENS
Date: 5/23/02
20c. Location - City or Town, State: OAKLAND, MARYLAND

21. Signature of Funeral Service Licensee: Robert H Durst M00167
22. Name and Address of Facility: P.O. BOX 243 DURST FUNERAL HOME - OAKLAND, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Atherosclerotic cardiovascular disease — 5 months
Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Ischemic cardiomyopathy — months
Due to (or as e consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hx of cerebrovascular accident

Chronic renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Donald R Richter
29c. License number: D30035
29d. Date signed (Month, Day, Year): 05-21-2002

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): Donald R. Richter, M.D 1533 Memorial Drive Oakland, MD 21550

State Registrar

31. Dete filed (Month, Day, Year): MAY 22 2002
32. Registrer's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18454

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Janet Carol Spiker
2. Date of Death Month Day Year: May 24, 2002
3. Time of Death: 10:39 a.m.
4a. Facility Name *(If not institution, give street and number)*: 171 Main Street
4b. City, Town, or Location of Death: Grantsville
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 577-58-8426
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 24, 1945
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Grantsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 171 Main Street
10f. Zip Code: 21536
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2 yrs
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Garrett Co. Board of Education

17. Father's Neme *(First, Middle, Last)*: Charles E. Spiker
18. Mother's Name *(First, Middle, Maiden Surname)*: Nora E. (Spiker)

19a. Informant's Name/Relationship *(Type, Print)*: Eleanor M. Beiler/sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25 N. Pennsylvania Ave., Box 489, Grantsville, MD 21536

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Country Side Crem. Date: May 25, 02
20c. Location - City or Town, State: Davidsville, PA

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Newman Funeral HOmes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. acute bronchospasm — 15 minutes

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic asthma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D-25759
29d. Date signed *(Month, Dey, Year)*: May 24, 2002

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Walter K. Naumann, MD, 106 Cemetery Rd., Accident, MD 21520

State Registrar

31. Dete filed *(Month, Day, Year)*: MAY 29 2002
32. Registrar's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18455

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Robert	Louis	Shank	May	25,	2002	7:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1212 Smouse Road	Oakland	Garrett

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-07-4153	1☒M 2☐F	91 Yrs.			Aug. 26,1910	West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	Garrett	Oakland	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1212 Smouse Road	21550	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8th		Carpenter	Lumber Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Albert ----- Shank	Annie ---- unk

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tracy L. Savage/Granddaughter	1222 Smouse Road, Oakland, Md. 21550

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Pleasant Valley Cem.	5/28/02	Oakland, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Bradley A. Stewart	Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Coronary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No	26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1☐Yes 2☐No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ P. Daniel Miller	H26154	5/29/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Daniel Miller D.O. 69 Wolf Acres Drive, Oakland, Md. 21550

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 29 2002	▶ Barbara B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy Helen Sweeney	May 24, 2002	3:39 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
11555 Timberbrook Drive	Waldorf	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-28-5989	1☐M 2☒F	82 Yrs.			Oct. 27, 1919	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Calvert	Lusby	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11555 Palo Alto Road	20657	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married XX Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WWII	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Physical Therapist	Physical Therapy

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Ernest Foerster	Helen Sak

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sue A. Murphy (DAUGHTER)	11555 Timberbrook Drive Waldorf, MD 20601

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metropolitan Crematory	May 25, 2002	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
MO 1095	Rausch Funeral Home, P.A. 4405 Broomes Island Rd. Port Republic, MD 20676

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ovarian Cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) Daughters Residence.

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Kaulka M Mathur	D28352	5-25-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Krishan Mathur, M.D. 3500 Old Washington Rd. # 102 Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 28 2002	Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20 + signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18457

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
DOROTHY ELIZABETH SLAGLE	MAY 21, 2002	4:10 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CARROLL COUNTY GENERAL HOSPITAL	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-20-4741	1 ☐ M 2 ☒ F	74 Yrs.			APRIL 4, 1928	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CARROLL	WESTMINSTER	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
436 HOOK ROAD	21157	UNITED STATES

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		SUPERVISOR	TELEPHONE COMPANY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ALBERT FRANCIS BOND	HILDA MAE ECKER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARSHA S. REEVE/DAUGHTER	704 WOODSIDE DRIVE, WESTMINSTER, MD 21157

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	EVERGREEN MEM GDNS	5/25/2002	FINKSBURG, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Robert A. Myers	MYERS FUNERAL HOME 91 WILLIS STREET WESTMINSTER, MD 21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO PULMONARY ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SMALL BOWEL OBSTRUCTION

Due to (or as a consequence of):

c. OVARIAN AND ENDOMETRIAL CANCER

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 ☐ Yes 2 ☒ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Khin M. Win-Chen M.D.	D0058342	05/21/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KHIN M. WIN-CHEN 200 MEMORIAL AVE., WESTMINSTER, MD 21157 CARROLL COUNTY GENERAL HOSPITAL

WJL 5 +25

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 22 2002	▶ Geneva G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18458

SCHYLASKE, VERNA

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Verna Arlene Schylaske			2. Date of Death: Month May, Day 17, Year 2002	3. Time of Death: 10:10A.M.
4e. Facility Name (If not institution, give street and number): Carroll County General Hospital	4b. City, Town, or Location of Death: Westminster	4c. County of Death: Carroll		
5. Social Security Number: 212-78-7600	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 89 Yrs.	If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Yeer): Sept. 7 1912
9. Birthplace (State or Foreign Country): PA				

Usual Residence of Decedent

10a. State: Maryland	10b. County: Carroll	10c. City, Town or Location: New Windsor	10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 9017 Tarr Drive	10f. Zip Code: 21776	10g. Citizen of What Country?: United States	

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):	16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker	16b. Kind of Business/Industry: own home	
17. Father's Neme (First, Middle, Last): William Kopp	18. Mother's Name (First, Middle, Maiden Surname): Amanda Jane Shomper		
19a. Informant's Name/Relationship (Type, Print): Kenneth Schylaske Son	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5921 Montgomery Street Baltimore, MD 21207		
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place): St. Lukes Cemetery	Date: May 20 2002	20c. Location - City or Town, State: New Windsor, MD
21. Signature of Funeral Service Licensee: Jeanne B Carey	22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784		

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE ENCEPHALOPATHY	5 DAYS
Due to (or as e consequence of):	b. BILATERAL PNEUMONIA	1 WEEK
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest	Due to (or as a consequence of): c.	
	Due to (or as e consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIO-PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number: D37949	29d. Date signed (Month, Dey, Yeer): May 17th 2002

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Alexander Boyd Leschewsky 2915 Stoner Ave, Westminster, MD 21157

State Registrar

31. Dete filed (Month, Day, Year): MAY 21 2002	32. Registrer's Signature: Renee D Sparks

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

WJ2 6

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 1 per phy 6/5/02,bg — For State Registrar use — *Certificate of Death* — Reg. No. 2002 18459

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anita Mae Thomas
2. Date of Death: Month 05 Day 21 Year 02
3. Time of Death: 8:50 PM
4a. Facility Name (If not institution, give street and number): 5631 Tulls Corner Road
4b. City, Town, or Location of Death: Marion
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 213-18-4696
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-30-19
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Somerset
10c. City, Town or Location: Marion Station
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5631 Tulls Corner RD
10f. Zip Code: 21838
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Rubberset Company

17. Father's Name (First, Middle, Last): Norman Williams
18. Mother's Name (First, Middle, Maiden Surname): Annie Evans

19a. Informant's Name/Relationship (Type, Print): Carmita Johnson - Cousin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5315 Tulls Corner RD Marion MD 21838

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Williams family Cemetery
Date: 5-25-02
20c. Location - City or Town, State: Marion, MD

21. Signature of Funeral Service Licensee: Hulton E. Ward
22. Name and Address of Facility: Anthony E. Ward F.H. 314 Cove St. Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION — Approximate Interval Between Onset and Death: Acute

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): DIABETES MALLITUS — Yrs
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Madhav D. Barhan
29c. License number: 12764
29d. Date signed (Month, Day, Year): ~~5/24/02~~ 5/23/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Madhav Barhan, 4384 Crisfield Hwy. Crisfield, MD 21817

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002
32. Registrar's Signature: Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Kay Louise Vaughn	May 17 2002	12:46 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2317 Pin Oak Rd.	Finksburg	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-38-9549	1☐ M 2☒ F	60 Yrs.			June 26 1941	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Finksburg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2317 Pin Oak Rd.	21048	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Registered Nurse	Greater Baltimore Medical Center

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Paul Strohm	Fae Knepp

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Wayne G. Vaughn, Sr. (Husband)	2317 Pin Oak Rd. Finksburg, MD 21048

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Pleasant Valley Cem.	May 21 2002	Pleasant Valley, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John K Agle	Pritts Funeral Home and Chapel P.A. 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic lung cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☑ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

None Known

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Howard Saiontz, M.D.	md # D15552	5/17/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Saiontz, M.D. 555 S. Center Street Westminster, Md 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 21 2002	▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WJL 10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18461

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM C. WILSON
2. Date of Death (Month, Day, Year): MAY 10, 2002
3. Time of Death: 5:16 PM
4e. Facility Name *(If not institution, give street and number)*: DEERS HEAD HOSPITAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-60-6059
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 49 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 5-27-52
9. Birthplace *(State or Foreign Country)*: D.C.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: NEWARK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 8842 MARSHALL CREEK ROAD
10f. Zip Code: 21841
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FENCE BUILDER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: MAX WILSON
18. Mother's Name *(First, Middle, Maiden Surname)*: MARY MYRTLE NALLEY

19a. Informent's Name/Relationship *(Type, Print)*: BETTY J. CRAFT FRIEND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8842 MARSHALL CREEK RD., NEWARK, MD., 21841

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: TRINITY GARDENS
Date: 5-13
20c. Location - City or Town, State: NEWARK, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Brain Lung Failure	5 years
Due to (or as a consequence of):	b. Renal Failure	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c. Hepatitis	3 years
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: History of alcohol, nicotine and drug dependence

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature end title of certifier: [signature] Virginia A. Dulany, MD
29c. License number: D33905
29d. Date signed *(Month, Day, Year)*: 5-11-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIRGINIA A. DULANY, MD PO BOX 2018 SALISBURY, MD., 21802

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 24 2002
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
GLADYS	VIRGINIA	WOOSTER	May	21	2002	1815 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-07-3862	1☐M 2☒F	94 Yrs.					February 16,1908	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Worcester	Pocomoke City	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
207 10th Street	21851	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
2	–	Paper hanger	Home Improvement

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Charles Walter Maddox	Sadie Elizabeth Pruitt

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Joyce Faye Frost/Daughter	2403 Old Snow Hill Rd., Pocomoke City, MD 21851

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Salisbury Crematory	5/23/02	Salisbury, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael A Dean M01129	Holloway Melson Funeral Home 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GI Bleed
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hypotension
Due to (or as a consequence of):
c. Acute Renal failure
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No	24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No	26. Place of Death (Check only one) Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) — 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	H0057410	5/22/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SIMONA ENG, M.D. 100 E. CARROLL ST. SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAY 24 2002	▶ Brenda G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

217-07-3862

GLADYS V. WOOSTER

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18463

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Robert Winebrener

2. Date of Death: Month 5 Day 18 Year 02

3. Time of Death: 6:17 P M

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 212-16-5078

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 10, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Union Bridge

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11 N. Main St.

10f. Zip Code: 21791

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): owner/operator

16b. Kind of Business/Industry: hardware store

17. Father's Name (First, Middle, Last): Thomas V. Winebrener

18. Mother's Name (First, Middle, Maiden Surname): Frances Casper

19a. Informant's Name/Relationship (Type, Print): Irene B. Winebrener/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 N. Main St., Box 308 Union Bridge, MD 21791

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mountain View Cem. Date: 5/22/2002

20c. Location - City or Town, State: Union Bridge, MD

21. Signature of Funeral Service Licensee: Catharine D. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 6 E. Broadway, Union Bridge, MD 21791

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Massive cerebellar Hemorrhage — Approximate Interval Between Onset and Death: 1 Day

Due to (or as a consequence of): b. Recent Cerebrovascular accident — UNK.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Khalil MD

29c. License number: D38915

29d. Date signed (Month, Day, Year): 5/19/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KHALIL FREIJ 295 Stoner Ave Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): MAY 23 2002

32. Registrar's Signature: Geneva G Sparks

WJL 20

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPM
02-2426-033
LINDA WALKER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061002:ITEMS#23a,ptII,27,28a-f per ME 0808 ss

Certificate of Death

Reg. No. 2002 18464

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LINDA D. WALKER	MAY 08, 2002	14:35 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3251 WALTERS LANE APARTMENT 102	FORESTVILLE	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
522-13-9739	1☐M 2☒F	49 Yrs.			Sept.24,1952	Washington,D.C.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	Forestville	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3251 Walters Lane #102	20747	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No *Specify:*	*Specify:* Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th		Homemaker	Self

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Nathaniel Walker	Lula Belle Booker

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Lionel D. Walker/son	4172 Suitland Rd. #401 Suitland,Md. 20747

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Fort Lincoln Cemetery	5/15/2002	Brentwood, Maryland

21. Signature of Funeral Service Licensee: W. J. Jeffers

22. Name and Address of Facility: Frazier's Funeral Home,Inc. 389 R.I. Ave., N.W. Wash.,DC 20001

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE NARCOTIC INTOXICATION

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HIV INFECTION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year) 5-8-02

28b. Time of Injury Found: 2:25p M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State) 3251 Walters Lane, #102 Forestville, Maryland

29a. Certifier (Check only one)
1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ana Rubio

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): MAY 09, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 07 2002

32. Registrar's Signature: Bonnie B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital** or **Attending Physician**: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18465

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles William Young

2. Date of Death: Month May, Day 20, Year 2002

3. Time of Death: 7:00 AM

4a. Facility Name (If not institution, give street and number): 2745 Ebbvale Road

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 220-22-8639

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 29 1926

9. Birthplace (State or Foreign Country): NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Manchester

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2745 Ebbvale Road

10f. Zip Code: 21102

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Steel Worker

16b. Kind of Business/Industry: Bethlehem Steel Co

17. Father's Name (First, Middle, Last): Pink W. Young

18. Mother's Name (First, Middle, Maiden Surname): Hettie Mae Gouge

19a. Informant's Name/Relationship (Type, Print): Lillie Young/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2745 Ebbvale Road Manchester, MD 21102

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Highview Memorial gar

Date: 5/24/2002

20c. Location - City or Town, State: Fallston, MD

21. Signature of Funeral Service Licensee: John K Aglt

22. Name and Address of Facility: Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — Approximate Interval Between Onset and Death: 5 min.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease — 3 1/2 yrs

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease
Atrial fibrillation

23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert McKean MD

29c. License number: D34298

29d. Date signed (Month, Day, Year): 5-21-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 532 Baltimore Blvd #201 Westminster, MD 21157

State Registrar

31. Date filed (Month, Day, Year): MAY 22 2002

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Job 10

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18466

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jun Rain Andersen
2. Date of Death: Month June Day 7 Year 2002
3. Time of Death: 0046 M
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: N/A
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min. 2
8. Date of Birth (Month, Day, Year): 06-07-02
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 623 Carolyn Road
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Charles William Andersen
18. Mother's Name (First, Middle, Maiden Surname): LaKeesha Ann Phillips

19a. Informant's Name/Relationship (Type, Print): LaKeesha Ann Phillips (Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 623 Carolyn Road, Glen Burnie, Maryland 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial pk.
Date: 6/11/2002
20c. Location - City or Town, State: Glen Burnie, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. severe prematurity — 2 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b. cardio respiratory failure — 2min
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [X] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: B57880
29d. Date signed (Month, Day, Year): June 7, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Parabh Gill 2003 Medical Parkway Annapolis, Md. 21401

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM #25 PER PHY G810 8/01/02 JH

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEN# 24a&25 PER MD. G808 6-10-02 JAB

Certificate of Death

2002 18467 Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Baby GIRL, Boyd.
2. Date of Death: Month April Day 06 Year 2002
3. Time of Death: 0552 M
4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: none
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min. 17
8. Date of Birth (Month, Day, Year): 04.06.02
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2807 Virginia Avenue
10f. Zip Code: 21213
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): none; College (1-4or 5+): none
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none
16b. Kind of Business/Industry: none
17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): Regina Boyd
19a. Informant's Name/Relationship (Type, Print): Sinai Hospital
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2401 W. Belvedere Avenue Baltimore, MD 21215
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Joseph B. Van Sant
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Extreme prematurity
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Hyalin membrane disease
Due to (or as a consequence of):
c. Cardiorespiratory collapse
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
twin gestation
No prenatal care
Unsure last menstrual period.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Ahmet Aybar MD
29c. License number: D48164
29d. Date signed (Month, Day, Year): 04.06.02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2401 W. Belvedere Avenue, BALTIMORE, MD. 21215

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature: Barbara G Hoard

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18468

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Beverly Marlene Beaver	June 6 2002	0820 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Anne Arundel Medical Center	Annapolis	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-36-3080	1☐ M 2☒ F	68 Yrs.			May 28, 1934	Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Anne Arundel	Deale	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
816 Cedar Drive	20751	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
3		None	None

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Marlin Beaver	Emma Elizabeth Karboski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Edward J. Czerwinski (Guardian)	816 Cedar Drive, Deale, MD 20751

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cedar Hill Cemetery	06/11/2002	Glen Burnie, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Hardesty Funeral Home P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration pneumonia	1 hr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Volvulus	2 d
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☒ No 9☐ Unknown	1☐ Live birth 2☐ Fetel death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D32036	6/6/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Go-J Sprouse 2108 D. Dorah Dr Mitchellville MD 21619

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18469

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Edith	Brothers	June 3, 2002	1:15p M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3318 Roscommon Drive	Glenelg	Howard

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
291-18-5366	1☐ M 2☒ F	79 Yrs.			Sept.11,1922	Ohio

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Howard	Glenelg	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3318 Roscommon Drive	21737	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th		Supervisor	Telephone Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert R. Hancock	Mary Barbara Masters

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Karl W. Brothers/Brother-in-law	P.O. Box 66 Bath, Ohio 44210

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BALTO. WASH CREM.	6-10-02	LAUREL, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Juanita R Thomas	Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. myocardial infarction	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. [illegible]	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month / Day / Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RHEUMATOID ARTHRITIS

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D75947	JUNE 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katrina Stuart MD 5540 Twin Knolls Rd Columbia MD 21045

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18470

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY BROWN
2. Date of Death (Month, Day, Year): June 5, 2002
3. Time of Death: 6:10
4a. Facility Name (If not institution, give street and number): Greater Baltimore Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-44-5784
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-18-1945
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2005 COLERIDGE CT
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISPATCHER
16b. Kind of Business/Industry: MD AVIATION (BWI)

17. Father's Name (First, Middle, Last): JOHN BROWN
18. Mother's Name (First, Middle, Maiden Surname): ELLEN MOORE

19a. Informant's Name/Relationship (Type, Print): ANDREA BROWN, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 415 CRAVEN ST, HAMPTON, VA 23661

20a. Method of Disposition: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT ZION CEMETERY
Date: 6-11-02
20c. Location - City or Town, State: MARYLAND

21. Signature of Funeral Service Licensee: ▶ Willie E Howell
22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Discontinuation of life support	minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Respiratory failure	2 months
Due to (or as a consequence of):		
c.	Sepsis of unknown etiology	2 months
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal failure, pancreatitis, encephalopathy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rebecca A. Ludwig MD
29c. License number: D36226
29d. Date signed (Month, Day, Year): June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rebecca A. Ludwig, M.D. GBMC, 6701 N. Charles Street, Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature: ▶ Bonnie B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Brown, Henry

Harvey Robert Bryant
02-2875-510
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar UNPENDED 061702: ITEMS#23a,27,28a-f per ME Code SS

Certificate of Death

Reg. No. 2002 18471

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
HARVEY ROBERT BRYANT	June	01	2002	5:50 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
2767 The Alameda	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-62-7178	1☐M 2☒F	35 Yrs.			06-26-1966	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2767 THE ALAMEDA	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		WASTE MANAGEMENT	SANITATION

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ROBERT BRYANT	GLADYS ROBERTS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GLADYS ROBERTS, MOTHER	2767 THE ALAMEDA, BALTO. MD 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MOUNT ZION	6/6/02	MARYLAND

21. Signature of Funeral Service Licensee: Willie E Howell

22. Name and Address of Facility: HOWELL FUNERAL HOME, 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ACUTE HEROIN INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☐No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) at scene

27. Manner of Death 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
Found: 6-1-02	Found: 5:25A M	1☐Yes 2☒No	Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2767 The Alameda, Baltimore, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	June 01, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	Jeanne B. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18472

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SELMA BRIGGS

2. Date of Death: Month 6 Day 6 Year 2002

3. Time of Death: 1650hrs

4a. Facility Name (If not institution, give street and number): 5035 Cornstack Road

4b. City, Town, or Location of Death: Marion Station

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 217-38-2134

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/30/1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Marion Station

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5035 Cornstack Road

10f. Zip Code: 21838

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Neme (First, Middle, Last): David Loukonen

18. Mother's Name (First, Middle, Maiden Surname): Bertha Regina Linquist

19a. Informant's Name/Relationship (Type, Print): Regina Welsh / Daughter

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 618 Virginia Ave., Baltimore, MD 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 6/10/2002

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LARGE CELL LYMPHOMA — 11 mos

Dua to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Dua to (or as a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: [signature] J. G. Santiano

29c. License number: D02556

29d. Date signed (Month, Day, Year): 6-6-02

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): J.G. Santiano, 100 8th St. Pocomoke City, MD 21851

State Registrar

31. Dete filed (Month, Day, Year): JUN 10 2002

32. Registrer's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law raquires that the death certificate be executed within 24 hours aftar death.

To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18473

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Edgar Willard Barker	June 1, 2002	3:45 pM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1000 Dalton Avenue	East Point	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-09-2535	1 X M 2 F	91 Yrs.			Jan. 21, 1911	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	East Point	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1000 Dalton Avenue	21224	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		Iron Worker	Iron

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Barker	Ethel Powell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mark Barker (Grandson)	7704 Wynbrook Road Baltimore, Maryland 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Parkwood Cemetery	6/6/02	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Elizabeth A. Selenski

22. Name and Address of Facility: Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Carcinoma Lung	yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension Due to (or as a consequence of):	yrs.
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Louis Olsen MD	D0018648	6/3/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LOUIS OLSEN, MD 1576 MERRITT BLVD., SUITE 14 BALTIMORE, MARYLAND 21222

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23a,Pt1,06/10/02dhb,G808,dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

State Registrar

Reg. No. 2002 18474

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Teresa M. Brightwell

2. Date of Death Month/Day/Year: MAY 31, 2002

3. Time of Death: 18:58 M

4a. Facility Name (If not institution, give street and number): SAINT AGNES HEALTH CARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-16-5109

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 95 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/17/1907

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1307 Gatefield Road

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James deLauder

18. Mother's Name (First, Middle, Maiden Surname): Mary Green

19a. Informant's Name/Relationship (Type, Print): Louis R. Brightwell/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1307 Gatefield Road Catonsville, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Michael Cemetery

Date: 6/04/2002

20c. Location - City or Town, State: Poplar Springs, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — Approximate Interval: 2 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] MD

29c. License number: D0027315

29d. Date signed (Month, Day, Year): May 31, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): M.C. Frydenberg St Agnes Hospital

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Brightwell, TERESA

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM#1&5-22 PER K.B. G808 6-10-02 jab

Certificate of Death

Reg. No. 2002 18475

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
BABY BOY BOYD	April 6, 2002	0552 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
NONE	XX 1 M 2 F	Yrs.		32	4-6-02	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.		BALTIMORE	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2807 VIRGINIA AVENUE	21213	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes XX No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
NONE	NONE	NONE	NONE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNK	REGINA BOYD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SINAI HOSPITAL	2401 W. BELVEDERE AVENUE BALTIMORE MD. 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 XX Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ JOSEPH B. VAN SANT (PER DVR)	STATE ANATOMY BOARD 655 W. BALTIMORE STREET BALTIMORE, MD. 21201

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Extreme prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hyalin membrane disease

Due to (or as a consequence of):

c. Cardiorespiratory collapse

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Twin gestation

No prenatal care

Unsure last menstrual period

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Ahmet Aybar MD	D048164	June 3, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHMET AYBAR, MD. 2401 W. Belvedere Avenue, Baltimore, MD. 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	Jennie G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

02-2985-510
THOMAS CAREW
RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar UNPENDED 061302:ITEMS#23a,27 per ME-Gbob ss

Reg. No. 2002 18476

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Thomas Scott Carew	JUNE 5, 2002	9:49P. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1027 CATHEDRAL STREET	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-48-8248	1☒M 2☐F	53 Yrs.			April 29 1949	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1027 Cathedral Street Apt. 15H	21201	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Seaman	Merchant Marine

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rueben W. Carew	Pauline Cool

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pauline C. Carew (mother)	1212 Odenton Rd, Odenton, MD. 21113

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Metro Crematory, Inc.	June 07 2002	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑Yes 2☐No	1☑Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	O.C.M.E.	JUNE 6,2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner (or Chief Medical Examiner) must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
EDWARD	COLLIVER	June 4, 2002	18:06 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-30-6005	XX 1 M 2 F	67 Yrs.			MAY 15,1935	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	TIMONIUM	1 Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1901 DUMONT COURT	21093	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3	GENERAL MANAGER	WHOLESALE AUTO AUCTION

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
SAMUEL	COLLIVER	LUCILLE	HARTZ

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RUTH COLLIVER / WIFE	1901 DUMONT COURT - TIMONIUM, MD 21093

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	GARDENS DULANEY VALLEY MEMORIAL	6/7/02	TIMONIUM, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Multisystem Organ Failure

Due to (or as a consequence of):

c. ARDS

Due to (or as a consequence of):

d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 X No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Rachna Gupta DO	RES 000	June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Rachna Gupta, DO 2401 W. Belvedere Ave, Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
JESSIE MAE DOUGHTY	JUNE 6 2002	2:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOSEPH RICHIE HOSPICE	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-40-9744	1 ☐ M 2 ☒ F	89 Yrs.			APRIL 29, 1913	SOUTH CAROLINA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1 ☒ Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2759 W. FAIRMOUNT AVE.	21223	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6TH GRADE		HOUSEKEEPER	HARBOR HOSPITAL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ANDREW GIBSON	HESTER BRUNSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DELORES DOUGHTY (DAUGHTER)	4836 CLIFTON AVE., BALTIMORE, MD. 21207

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	WOODLAWN CEMETERY	06-12-02	BALTIMORE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. chronic renal insufficiency	Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): diabetes	Years
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiple Myeloma

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown	1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
	M	1 ☐ Yes 2 ☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ E Tso MD	D24170	June 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
E. Tso MD Richey Hospice 820 N. Eutaw St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	▶ Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Jessie Doughty 6/6/02 2:20 AM

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Madeleine Greffen Deitrich	June 4 2002	8:30 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
468 Dominique Court	Sykesville	Carroll

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-22-7355	1☐ M 2☒ F	73 Yrs.			Aug. 14, 1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4424 Eldone Road	21229	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Secretary	Defense

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Milton Warren Greffen, Sr.	Margaret May Shiloh

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janet L. Holly Daughter	468 Dominique Court, Sykesville, MD 21784

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Holy Family Cemetery	6-8-2002	Randallstown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. OVARIAN CANCER	18 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) daughters residence

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ EW Cole MD	D16354	6/5/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ENSER COLE STAGNES 900 CATON AVE BALT MD 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #18 PERFH G808 6/10/02 JH

Certificate of Death

Reg. No. 2002 18480

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
JANICE	Z.	DEVORAH	JUNE	6	2002	8:55PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HOSPICE OF BALTIMORE-GILCHRIST CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-80-4097	1☐ M 2☒ F	34 Yrs.					DEC 25 1967	MD.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7616 CARLA ROAD	21208	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5 +	SCHOOL PSYCHOLOGIST	BALTO. CITY SCHOOLS

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
HAROLD SINGERMAN	~~ROSALYN~~ ROSLYN KURNOW

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. STEPHEN DEVORAH/HUSBAND	7616 CARLA ROAD BALTIMORE, MD.21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory, or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BETH JACOB CONGREGATION	6/7/02	FINKSBURG, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Edward C. Rund	SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Colorectal cancer	13 months
Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	
Due to (or as a consequence of):	
c.	
Due to (or as a consequence of):	
d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.	23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
	24a. Was an autopsy performed? 1☐ Yes 2☒ No
	24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Menner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	
1☒	**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated.
2☐	**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Helen M Gordon	D0051926	June 7, 2002

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
Helen M. Gordon 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	▶ Bonnie B Spath

DHMH 16 Rev 6/95

ORIGINAL

Devorah, Janice June 6, 2002 8:55 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18481

Patient known as Dixon, Spencer

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
SPENCER DIXON	June 1, 2002	1300 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital of Baltimore	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-40-2734	1☒M 2☐F	60 Yrs.			11-12-1941	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3012 SPAULDING AVE	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		LABORER	CROMPTON KNOWLES

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SPENCER TILL	DOROTHY DIXON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LEAH DIXON, WIFE	3010 SPAULDING AVE, BALTO. MD 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MOUNT ZION	6-6-02	MARYLAND

21. Signature of Funeral Service Licensee: Willie E Howell IV

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 60 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Mycardal Infarction
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Sunny Kim MD	RES 000	June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUNNY R. KIM, MD 2401 W. Belvedere Ave, Balto, MD 21215

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	Barbara B. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18482

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MABEL ESWORTHY
2. Date of Death: Month JUNE Day 6 Year 02
3. Time of Death: 1:50 AM
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-18-8583
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 15 1923
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel Co.
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5615 Harbor Valley Drive
10f. Zip Code: 21225
10g. Citizen of What Country? USA

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: U.S. Postal Service
17. Father's Name (First, Middle, Last): William Randolph Bishop
18. Mother's Name (First, Middle, Maiden Surname): Ella Mae Kern
19a. Informant's Name/Relationship (Type, Print): Judith A. Hall (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5615 Harbor Valley Drive, Baltimore, Md. 21225
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery
Date: 6/10/2002
20c. Location - City or Town, State: Baltimore, Md.
21. Signature of Funeral Service Licensee: John F. Collins
22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Ave. Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. STROKE
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. ATHEROSCLEROSIS
Due to (or as a consequence of):
c. HYPERLIPIDEMIA
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: SIX DAYS

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No
25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] (MD)
29c. License number: REF001
29d. Date signed (Month, Day, Year): JUNE 6 02
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): UMEADI, ONWURA GABRIEL - HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER ST.

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature:

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18483

ERWIN, TAMMY S.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Tammy	S.	Erwin	JUNE 5 2002	5:25 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Villa St. Michael Nursing Home	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-96-4183	1☐ M 2☒ F XX	33 Yrs.			09 06 68	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	XX 1 Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3112 Presbury Street	21216	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married X 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No X If Yes, Give Year or Dates:	1☐ Yes 2☒ No XX Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th grade	na	Unemployed	Unemployed

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Larry L. Grimes	Vanessa Evans

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Vanessa McCarthy-Mother	2910 Pressman Street, Baltimore Md 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation X 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metro Crematory Inc	6/8/02	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John B. Johnson Jr.	March F/H West 4300 Wabash Ave, Baltimore Md 21215

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Probable Myocardial infarction	2hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Anoxic Encephalopathy	6yrs
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
S Ramesh	D30641	June 7 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ramesh Sabapathi 3400 Erdman Avenue Baltimore MD 21213

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar AMEND ITEM #7&26 PER PHY G808 6/10/02 jb **Certificate of Death**

Reg. No. 2002 18484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Francis Ernst	June 3, 2002	1:15 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
600 Light Street Apt. 927	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-16-0203	1☒ M 2☐ F	80 ~~79~~ Yrs.			June 4, 1921	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
600 Light Street Apt. 927	21230	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Police Officer	Baltimore City

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
Frank Ernst	Elizabeth Gilmore

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Florence Ernst/Wife	600 Light Street Apt. 927 Baltimore, Maryland 21230

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Sacred Heart of Jesus	6/7/02	Baltimore, Maryland

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SUDDEN CARDIAC DEATH — Approximate Interval Between Onset and Death: immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ISCHEMIC CARDIOMYOPATHY — 10 years

Due to (or as a consequence of):

c. CORONARY ARTERY DISEASE — 20 years

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Robert V. Zajony MD	D31230	6/3/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT V. ZAJONY, M.D. SUITE 103, 7505 OSLER DR., TOWSON

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

ADH
ERIC FLOYD
02-2979-510

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar AMEND/UNPEND 061802:ITEMS#19a per fh;23a,27 per ME C808 ss

Reg. No. 2002 18485

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Eric	Raymond	Floyd	JUNE	5,	2002	1228 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARYLAND GENERAL HOSPITAL	BALTIMORE CITY	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-76-0982	XX 1 M 2 F	43 Yrs.					03 27 59	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
555 Laurens Street	21217	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
XX Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	na	Laborer	Various Jobs

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Floyd	Jennie O. Morris

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Jennie O. ~~Morris~~ Morris-Mother	555 Laurens Street, Baltimore Md 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Mt. Zion Cemetery	6/10/02	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Willie Edmonds	March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. THROMBUS OF LEFT ANTERIOR DESCENDING CORONARY ARTERY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✓ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ✓ Yes 2 No	1 ✓ Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 X DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)

1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	OCME	JUNE 6, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN HOGAN 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 2002 18486

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
Samuel	Ford	June 5, 2002	4:30A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Baltimore Rehabidatation and Extended Care	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-26-8536	1☒M 2☐F	73 Yrs.			Nov. 18, 1928	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3102 Brightwood Ave.	21207	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1952 1954	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
UnKnown		UNKnown	UnKnown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
John A. Ford	Alverta E. Huesen

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Veterans Hospital	10 North Greene St., Baltimore, Md. 21201

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Md. Veterans Cemetery	6/10/02	Crownsville, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	3 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month, Day, Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D00032548	June 5, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PERRY L COLVIN MD 10 North Greene Street, Baltimore

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

212-26-8536

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Francisco Febles

2. Date of Death (Month, Day, Year): June 8, 2002

3. Time of Death: 3:35 pm

4a. Facility Name (If not institution, give street and number): 1101 St. Paul St., Apt. 2202

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 579-50-5251

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 12 1929

9. Birthplace (State or Foreign Country): Puerto Rico

Usual Residence of Decedent

10a. State: Puerto Rico

10b. County:

10c. City, Town or Location: Guaynabo

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 6 St. # F1

10f. Zip Code: 00921

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: late 1950's

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 8+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): physician

16b. Kind of Business/Industry: health care

17. Father's Name (First, Middle, Last): Francisco Febles

18. Mother's Name (First, Middle, Maiden Surname): Rosalia Vizcarrondo

19a. Interment's Name/Relationship (Type, Print): Adrian Febles, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00910: P.O. Box 19905 Fdez. Juncos Sta. SanJuan P.R.

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Puerto Rico National Cemetery

Date: 6/13/02

20c. Location - City or Town, State: Bayamon, P.R.

21. Signature of Funeral Service Licensee: Wanda L Lemmer

22. Name and Address of Facility: Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic carcinoma (adenocarcinoma) — 8 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DM II

Chronic obstructive pulm disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) son's home

27. Manner of Death: 1 [X] Naturet 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Timothy J Krohe, MD

29c. License number: D44290

29d. Date signed (Month, Day, Year): 9 June 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TIMOTHY L. KROHE, 10755 Falls Road Suite 200 Lutherville, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: George B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Amend Item 19a per Pw.o. Atty. and FH
G812,10/24/02 SB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

For State Registrar AMEND ITEM #12,23&26 PER PHY G808 6/10/02 JH

Certificate of Death

Reg. No. 2002 18488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Foster

2. Date of Death: Month 5 Day 25 Year 2002

3. Time of Death: 1130A M

4a. Facility Name (If not institution, give street and number): Dudley Richardson Alternative Care Catonsville

4b. City, Town, or Location of Death:

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 235-10-3356

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): 11 18 18

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3914 Grantley Road

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th grade

College (1-4or 5+): na

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance

16b. Kind of Business/Industry: Baltimore Co.

17. Father's Name (First, Middle, Last): Lonnie Foster

18. Mother's Name (First, Middle, Maiden Surname): Agnes Thaston

19a. Informant's Name/Relationship (Type, Print): OREATHA B. FOSTER ~~Aretha Foster~~ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3914 Grantley Road, Baltimore md 21215

20a. Method of Disposition: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arbutus Memorial Park

Date: 5/30/02

20c. Location - City or Town, State: Arbutus, Md

21. Signature of Funeral Service Licensee: John B. Johnson Jr

22. Name and Address of Facility: March F/H West 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ~~Acute~~ Myocardial Infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home ~~5 [ ] Residence~~ 6 [X] Other (Specify) ASSISTED LIVING

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anil Uberoi MD

29c. License number: D26748

29d. Date signed (Month, Day, Year): 5/28/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANIL UBEROI MD 4419 FALLS RD BALTO MD 21211

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: B Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 26,28f,per For State Registrar,G808,06/10/02dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18489

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL B. FOXWELL

2. Date of Death (Month, Day, Year): JUNE 4 2002

3. Time of Death: 10:00 AM

4a. Facility Name (If not institution, give street and number): 203 Leslie Avenue

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-88-8277

6. Sex: XX 1 M 2 F

7. Age (In yrs. last birthday): 30 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 15, 1971

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1 Yes 2 XX No

10e. Street and Number: 203 Leslie Avenue

10f. Zip Code: 21236

10g. Citizen of What Country? USA

11. Marital Status: XX 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes XX 2 No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+): 2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Printer

16b. Kind of Business/Industry: Blueprint Industry

17. Father's Name (First, Middle, Last): Lurman Hubert Foxwell, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Lorna Gail Brumgard

19a. Informant's Name/Relationship (Type, Print): Lorna G. Foxwell (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8614 Pleasant Plains Rd. Towson, Md. 21286

20a. Method of Disposition: 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.

Date: 6-8-02

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Name and Address of Facility: LASSAHN FUNERAL HOME 7401 BELAIR RD. BALTIMORE, MD. 21236

Physician /Medical Examiner

26 28f dhb

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Self-inflicted suffocation and hanging

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Drug abuse

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 XX Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 XX Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year): 06-04-02

28b. Time of Injury: 1305 PM

28c. Injury at Work? 1 Yes 2 X No

28d. Describe how injury occurred: Self-inflicted hanging

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 203 Leslie Ave., Balto., MD 21236

29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 XX Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Crotton O'Donovan, M.D.

29c. License number: D07632

29d. Date signed (Month, Day, Year): 06-05-02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CROSSAN O'DONOVAN 2112 DUNDALK AVE BALTO MD 21222

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: Donna G Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard Granger
2. Date of Death: Month June Day 6, Year 2002
3. Time of Death: 2:15 A M
4a. Facility Name (If not institution, give street and number): University of Maryland Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 231-58-7310
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUN 18, 1946
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 607 N. PAYSON STREET
10f. Zip Code: 21217
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] Yes 2 [ ] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT list retired): DRIVER
16b. Kind of Business/Industry: TRUCKING COMPANY

17. Father's Name (First, Middle, Last): WILLIE GRANGER
18. Mother's Name (First, Middle, Maiden Surname): SALLIE GRANGER

19a. Informant's Name/Relationship (Type, Print): JOSEPHINE WELLS (SISTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 607 N. PAYSON STREET BALTIMORE, MD 21217

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PK.
Date: 6/12/02
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Cardio pulmonary Arrest
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Advanced HTLV-1 Leukemia/Lymphoma
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: P Mark, D.O.
29c. License number: H0057441
29d. Date signed (Month, Day, Year): 6/6/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peyman Markazi, D.O. 22 South Greene St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002
32. Registrar's Signature: James G Sparks

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18491

NAME KNOWN TO PHYSICIAN: GUY, MAURICE C.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Maurice C. Guy	May 25, 2002	10:58P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
VA MARYLAND HEALTHCARE SYSTEM	PERRY POINT	CECIL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-12-4495	1☒M 2☐F	75 Yrs.			Sept. 25, 1926	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Havre de Grace	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1333 Old Post Road	21078	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: 1944-46	1☐Yes 2☒No *Specify:*	*Specify:* white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8	0	carpenter	residential

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Eugene Guy	unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Marlene Diggs/daughter	8425 Thornton Road, Timonium,MD 21293

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Joseph B. Van Sant	State Anatomy Board, 655 W. Baltimore Street, Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	UNKNOWN
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Samir Kheiri MD	D0052064	May 25, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR KHEIRI, M.D., VA MARYLAND HEALTHCARE SYSTEM, PERRY POINT, MARYLAND 21902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SUSIE A GRIFFIN
2. Date of Death (Month, Day, Year): June 5, 2002
3. Time of Death: 5:05PM
4a. Facility Name (If not institution, give street end number): BON SECOUR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 462-42-1090
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2 - 11 - 1920
9. Birthplace (State or Foreign Country): MS

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2421 W. LAFAYETTE AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: HOUSEKEEPING

17. Father's Name (First, Middle, Last): NELSON TERRY
18. Mother's Name (First, Middle, Maiden Surname): VIRGIL HUNTER

19a. Informant's Name/Relationship (Type, Print): DENISE G. JOHNSON/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4310 FAIRVIEW AVENUE BALTIMORE, MARYLAND 21216

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY
Date: 6-8-02
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: James A. Morton
22. Name and Address of Facility: JAMES A. MORTON & SONS F.H., INC. 1701-31 LAURENS ST. BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. END STAGE CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest:
b. PNEUMONIA
Due to (or es e consequence of):
c. SEPTIC Shock
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No
26. Piece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: R.M. Shah MD R. M. SHAH, M.D.
29c. License number: D0019668
29d. Date signed (Month, Dey, Year): 5/7/02

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): BON SECOUR Hospital, Baltimore, MARYLAND

State Registrar

31. Date filed (Month, Dey, Year): JUN 10 2002
32. Registrer's Signature: George D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a, per [illegible] For Registrar 6/10/02dhb,G808

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18493

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Bernard Thomas Hilte	June 5, 2002	7:30 A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
101 Bayside Drive	Dundalk	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-32-7301	1☒ M 2☐ F	66 Yrs.			July 21, 1935	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
101 Bayside Drive	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 Years		Manufacturing	Pallet Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas Hilte	Marie Stadler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Betty M. Hilte (Wife)	101 Bayside Drive Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gardens of Faith Cem.	6/8/2002	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic lung Cancer	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	9 mo
	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 9☐ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Ismael Attarassi MD	028097	6/5/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1576 Merritt Blvd Suite 14, Balt, Md. 21222

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM #30 PER DVR G808 6/10/02 JH **Certificate of Death**

Reg. No. 2002 18494

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

HOLLEY, HAROLD

1. Decedent's Name (First, Middle, Last): Harold Holley			2. Date of Death: Month 6 Day 4 Year 2002	3. Time of Death: 8:52P
4a. Facility Name (If not institution, give street and number): Levindale Hospital	4b. City, Town, or Location of Death: Baltimore	4c. County of Death: N/A		
5. Social Security Number: 219-18-9093	6. Sex: 1☑M 2☐F	7. Age (In yrs. last birthday): 77 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 12, 1925	9. Birthplace (State or Foreign Country): MD			

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☑Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2434 W. Belvedere Ave	21215	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☑Widowed 4☐Divorced	1☑Yes 2☐No If Yes, Give Year or Dates: 1943	1☐Yes 2☑No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12): 12	College (1-4or 5+)	Recreation & Park	City OF Baltimore

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Wallace Johnson	Clara Johnson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara Christian / niece	1211 Ethan St Balt. MD 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☑Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Bay View Crematin	6/6/02	Baltimore, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Hart P. Close Funeral Service, P.A. 709 Fessier St., Baltimore MD 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxia	
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sepsis	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one)
1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
NRajapakse MD	MD D57465	6/5/02

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)
2434 W. Belvedere Av. Balt. MD. NIROSHI SHARLENE RAJAPAKSE

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
JUN 10 2002	G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Deborah Timmons Heath
02-2947-510
crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar **UNPENDED 061802: ITEMS #23a, 27, 28a-f per ME 0808 ss**

Certificate of Death

Reg. No. 2002 18495

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
DEBORAH TIMMONS HEATH	June	04	2002	11:25 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3415 Lyndale Avenue	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-68-2678	1☐ M 2☒ F	46 Yrs.			02-28-1956	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3415 LYNDALE AVE	21213	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		WELDER	STEEL INDUSTRY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CHARLEY TIMMONS	SARAH I. GODARD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SARAH TIMMONS, MOTHER	3415 LYNDALE ABE, BALTO. MD 21213

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	METRO CREMATION	6/8/82	MARYLAND

21. Signature of Funeral Service Licensee: Willie E Howell

22. Name and Address of Facility: HOWELL FUNERAL HOME, 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☐ No 3☒ Unknown

23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) at scene

27. Manner of Death 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year) Found: 6-4-02

28b. Time of Injury Found at: 10:30P M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Found at residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 3415 Lyndale Ave., Baltimore, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	June 05, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mary G. Apple, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	▶ Penny B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18496

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
SARAH	B.	HURWITZ	MAY 30, 2002	5:40 P M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LEVINDALE HEBREW HOME	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-48-1382	1☐M 2☒F	101 Yrs.			JAN.31,1901	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7111 PARK HEIGHTS AVENUE #601	21215	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOUSEWIFE	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
HYMAN	BADDOCK	BERTHA	(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
BENNO HURWITZ / SON	10609 BROOKLAWN ROAD - OWINGS MILLS, MD 21117

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	BALTIMORE HEBREW CEM.	6/7/2002	REISTERSTOWN, MD

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. A S C V D	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. RESPIRATORY FAILURE	
	Due to (or es e consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☒No 9☐Unknown

23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Howard B. Cohen M.D.

29c. License number 21680

29d. Date signed (Month, Day, Year) 5/31/2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HOWARD B. COHEN, M.D. 6717 PARK HEIGHTS AVENUE BALTIMORE, MD 21215

State Registrar

31. Date filed (Month, Day, Year) JUN 10 2002

32. Registrar's Signature ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 27, per ME 08,06/10/02dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

For State Registrar

Reg. No. 2002 18497

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MARGARET HEALY	5/22/02	4:20 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LAUREL REGIONAL HOSPITAL	LAUREL, MD	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
382-12-4307	1 ☐ M 2 ☒ F	80 Yrs.			JAN. 11, 1922	PENNSYLVANIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	PRINCE GEORGE	LAUREL	1 ☐ Yes 2 ☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10510 HUNTERS WAY	20723	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	1	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
NICHOLAS RAFFERTY	CATHERINE McCLIMATE

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
KAREN UCHACA/ DAUGHTER	10510 HUNTERS WAY, LAUREL, MARYLAND 20723

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ST. MARY'S CEMETERY	5/24/02	PATTON, PENNSYLVANIA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. RESPIRATORY FAILURE	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CORONARY ARTERY DISEASE	
	Due to (or as a consequence of):	
	c. HIP FRACTURE	
	Due to (or as a consequence of):	
	d. ATRIAL FIBRILLATION	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _____ 9 ☐ Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1 ☒ Yes 2 ☐ No	Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☒ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	5/21/02	7:00 PM	1 ☐ Yes 2 ☒ No	AT FELL TRYING TO STAND

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
NURSING HOME	LAUREL, MD

29a. Certifier (Check only one) 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	D50349	5/22/02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
7350 VAN DUSEN RD SUITE 110 LAUREL, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2002 18498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
William Ralph Johnson	June 7 2002	5:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
North Arundel Hospital	Glen Burnie	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
254-10-9944	1☒M 2☐F	86 Yrs.			Nov. 2, 1915	Georgia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Calvert	Dunkirk	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1920 North Plantation Drive	20754	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Gas Construction Forman	BG&E

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Willie E. Johnson	Mary Hegwood

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred K. Johnson (Spouse)	1920 North Plantation Drive, Dunkirk, MD 20754

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Glen HavenCemetery	June 10 2002	Glen Burnie, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery (Month Day Year)
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ George E. Wicks III M.D.	D41365	June 7, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George E. Wicks III MD, 301 Hospital Drive, Glen Burnie, MD, 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Johnson, William

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18499

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hilda Margaret James

2. Date of Death — Month: June; Day: 6; Year: 2002

3. Time of Death: 12:45 P.M.

4a. Facility Name (If not institution, give street and number): Charleston Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-66-6828

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): 02/22/1909

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 709 Maiden Choice Lane

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Insurance

17. Fether's Name (First, Middle, Last): William Carew

18. Mother's Name (First, Middle, Maiden Sumame): Catherine Butler

19a. Informant's Name/Relationship (Type, Print): Dorothy Carew/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 Evesham Ave. Baltimore, MD 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): New Cathedral Cemetery

Date: 06/10/02

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction — minutes

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature], MD

29c. License number: D47447

29d. Date signed (Month, Day, Year): June 7 2002

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Andrew Lazaris 711 Maiden Choice Lane Catonsville Md.

State Registrar

31. Date filed (Month, Day, Year): JUN 10 2002

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mantel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-I show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after deeth.

To the Funerel Director: After this certificate has bean signed by the attending physician and completely fillad in by the funerel director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For Stete Registrer

Certificate of Death

Reg. No. 2002 18500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
WALTER JAKUBIK	5 / 31 / 02	06 00AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Center	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-01-4109	1☒M 2☐F	91 Yrs.			June 27,1910	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore City	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
401 Hornel Street	21224	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		Loading	Longshoreman

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Walter Jakubik	Alexandria Mieduszewski

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John M. Jakubik (Brother)	410 Hornel Street Baltimore, Maryland 21224

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Baltimore-Washington	6/7/02 Crematory	Laurel, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Elizabeth Selinski	Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASCVD	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month / Day / Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA.

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No	1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medicel Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D37089	5 31 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BRUCE LEFF 5505 HOPKINS BAYVIEW CR. BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 10 2002	

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2002 18293

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RUSSELL HOWARD SEIFERT
2. Dete of Deeth: Month MAY Dey 15, Year 2002
3. Time of Death: 9:16 P.M.
4a. Facility Neme *(If not institution, give street end number)*: MARINER HEALTH OF FOREST HILL
4b. City, Town, or Location of Death: FOREST HILL
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 217-14-6730
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. lest birthdey)*: 79 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 13, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Md.
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☐ No — X
10e. Street end Number: 2609 Cherry Laurel Court
10f. Zip Code: 21009
10g. Citizen of What Country?: U.S.A.

11. Merital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Detes: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☐ No — X — *Specify:*
14. Race - American Indian, Black, White, etc. — *Specify:* white

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 years; College (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: pressman
16b. Kind of Business/Industry: newspaper industry

17. Father's Neme *(First, Middle, Last)*: William Seifert
18. Mother's Name *(First, Middle, Maiden Surname)*: Emily unknown Seifert

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Ardella Seifert/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2609 Cherry Laurel Court, Abingdon, Md. 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gdns.
Date: 5/18/2002
20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: ▶ Carol Lumberg
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. AORTIC VALVE ENDOCARDITIS

Due to (or as a consequence of):
b. CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

Due to (or as e consequence of):
c. Congestive Heart failure

Due to (or as e consequence of):
d. Coronary Artery disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Hypertension, cerebral vascular disease, diabetes mellitus, hypothyroid atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ [signature] MD DO
29c. License number: H41069
29d. Date signed *(Month, Dey, Yeer)*: MAY 16, 2002

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Dr. Stanley Kman 1308 Business Ctr Way #102 Edgewood 21040

10

State Registrar

31. Date filed *(Month, Day, Year)*: MAY 20 2002
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Merylend Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit